Living Evidence

Partnerships and technology for up to date, reliable evidence

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Lead, Evidence Systems, Cochrane
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Trusted evidence.
Informed decisions.
Better health.

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- Lead, Evidence Systems
- Lead, Living Evidence Network

Cochrane Australia

- Senior Research Fellow
- Research Group Leader

MONASH University

covidence

- Co-founder and CEO

theAlfred

- Infectious Diseases Physician


American Journal of PHYSIOLOGY
CANCER RESEARCH
THE JOURNAL
DISEASES of the NERVOUS SYSTEM
MILITARY MEDICINE

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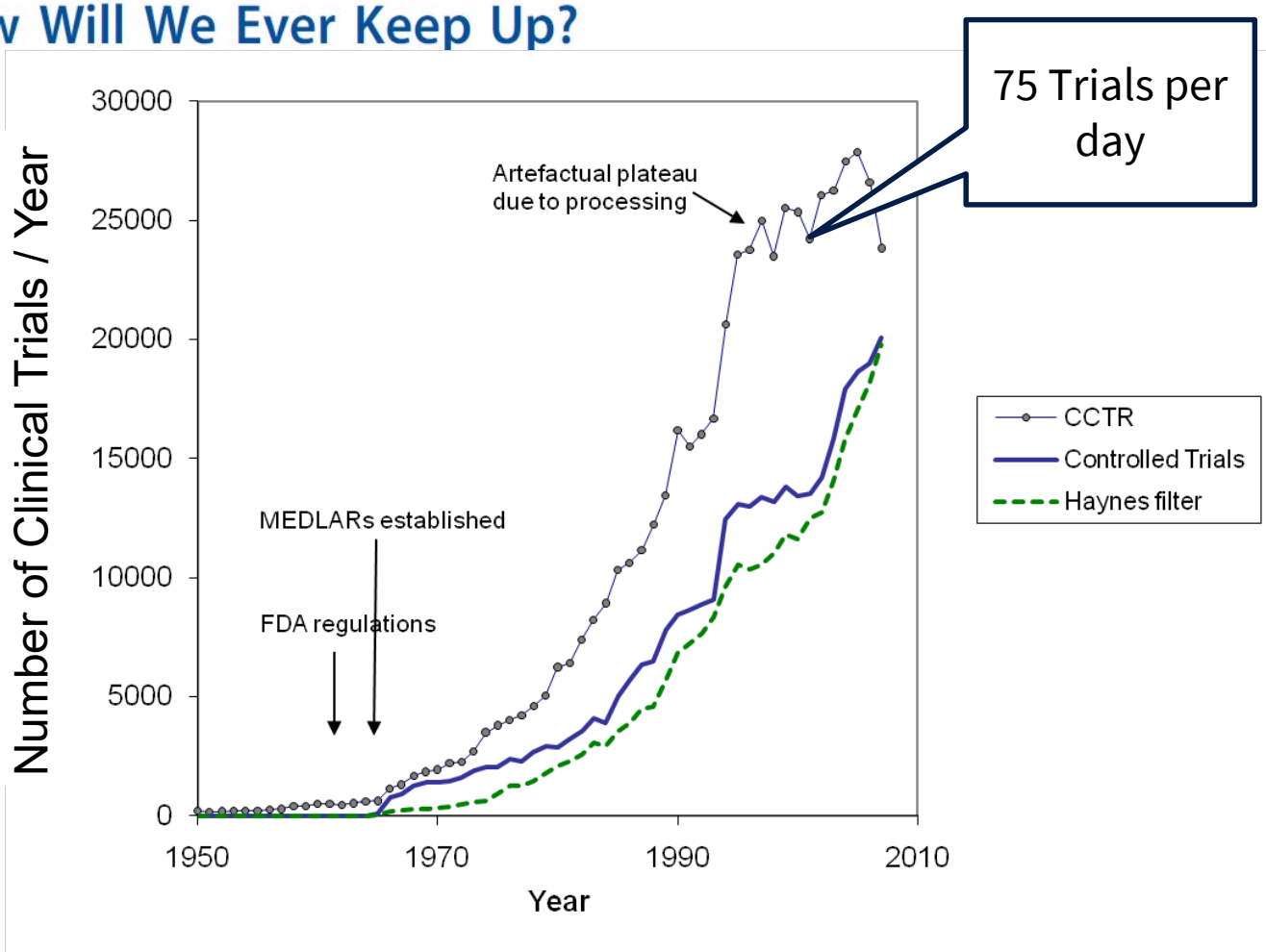
OPEN ACCESS Freely available online

PLoS MEDICINE

Policy Forum

Seventy-Five Trials and Eleven Systematic Reviews a Day: How Will We Ever Keep Up?




BIG DATA
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Annals of Internal Medicine®

THE LITERATURE OF MEDICINE | 1 MARCH 1987

The Medical Review Article: State of the Science

CYNTHIA D. MULROW, M.D., M.Sc

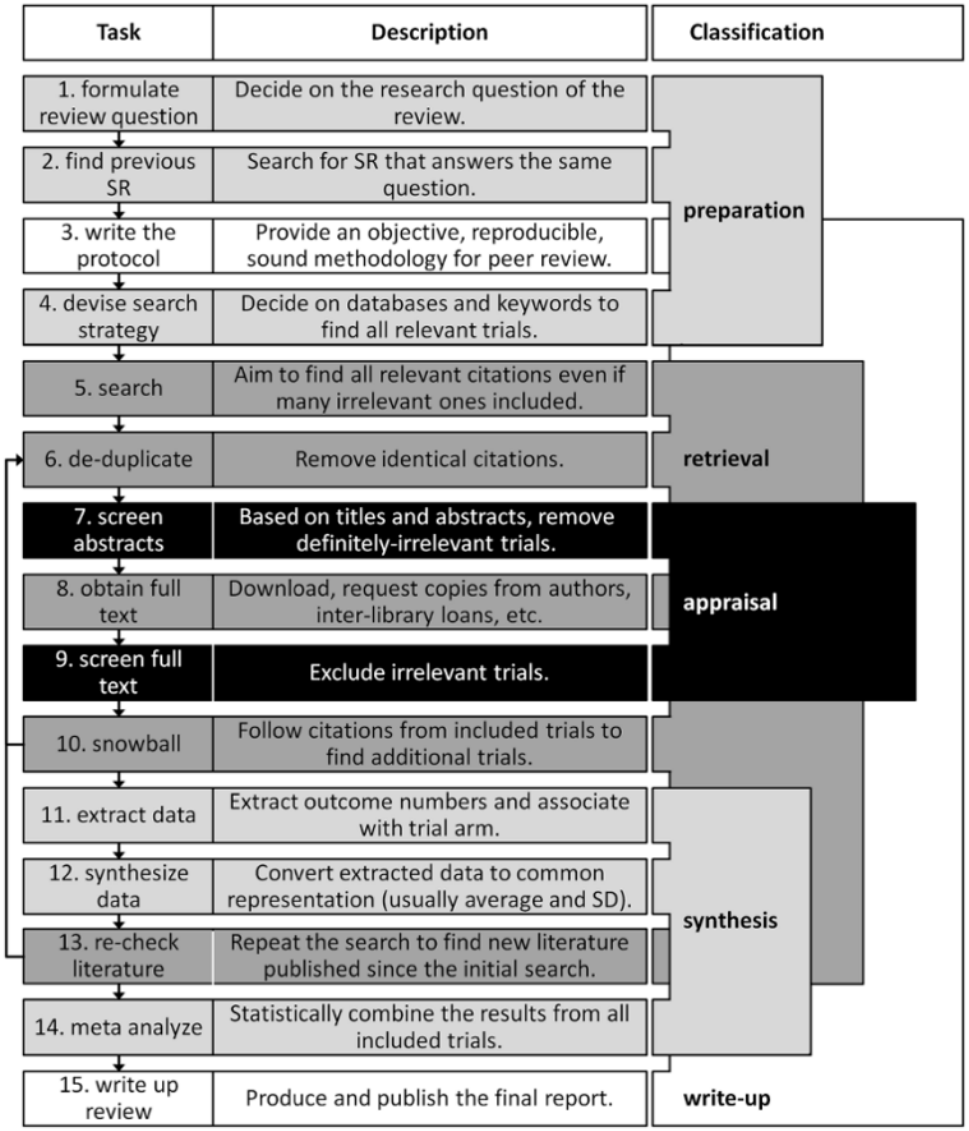
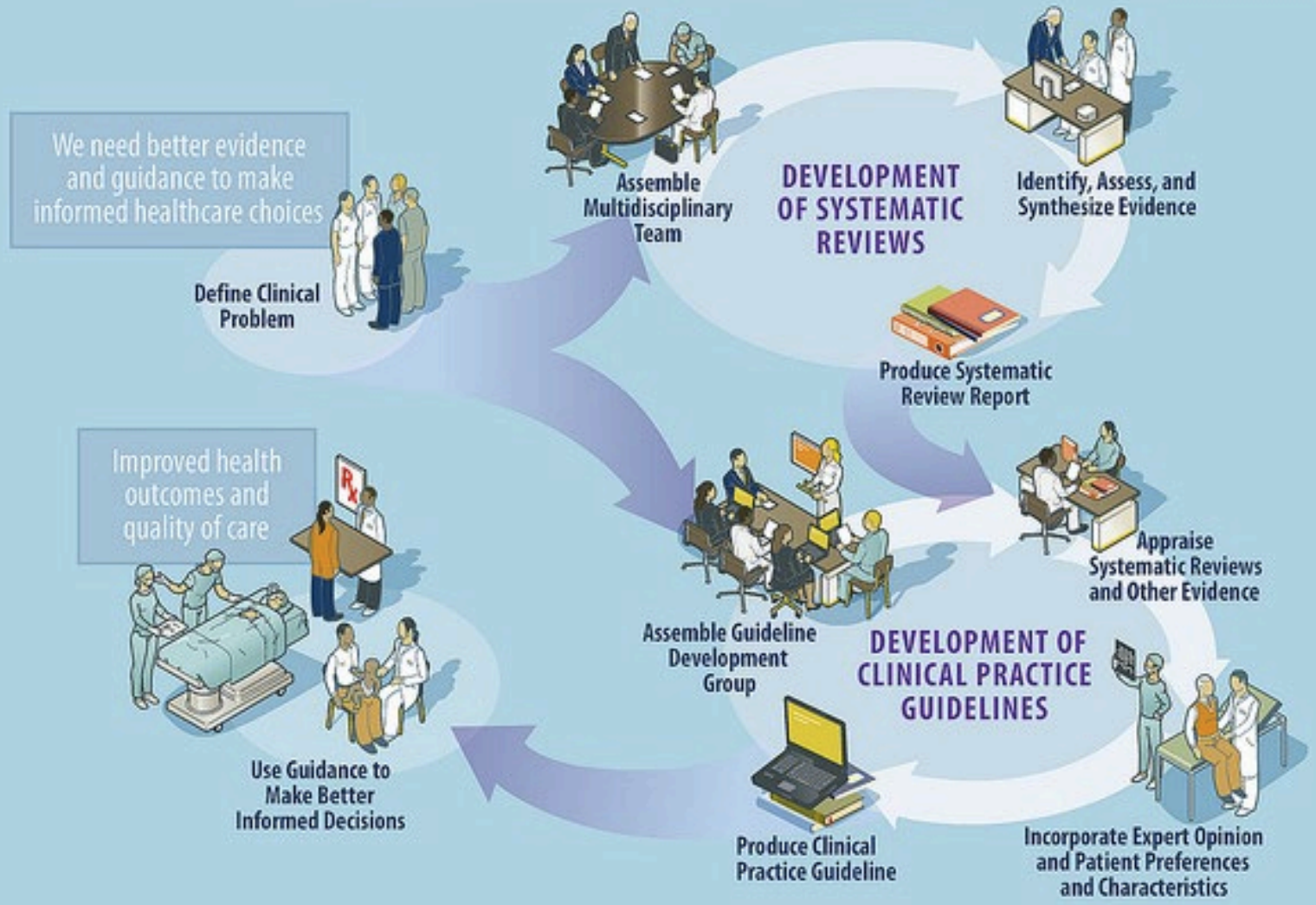


Figure 1 Existing methods for systematic reviews follow these steps with some variations. Not all systematic reviews follow all steps. This process typically takes between 12 and 24 months. Adapted from the Cochrane [10] and CREBP [11] Manuals for systematic reviews. *SR* systematic review, *SD* standard deviation.

Systematic Reviews and Clinical Practice Guidelines Improve Healthcare Decision Making

Click on any text for more information



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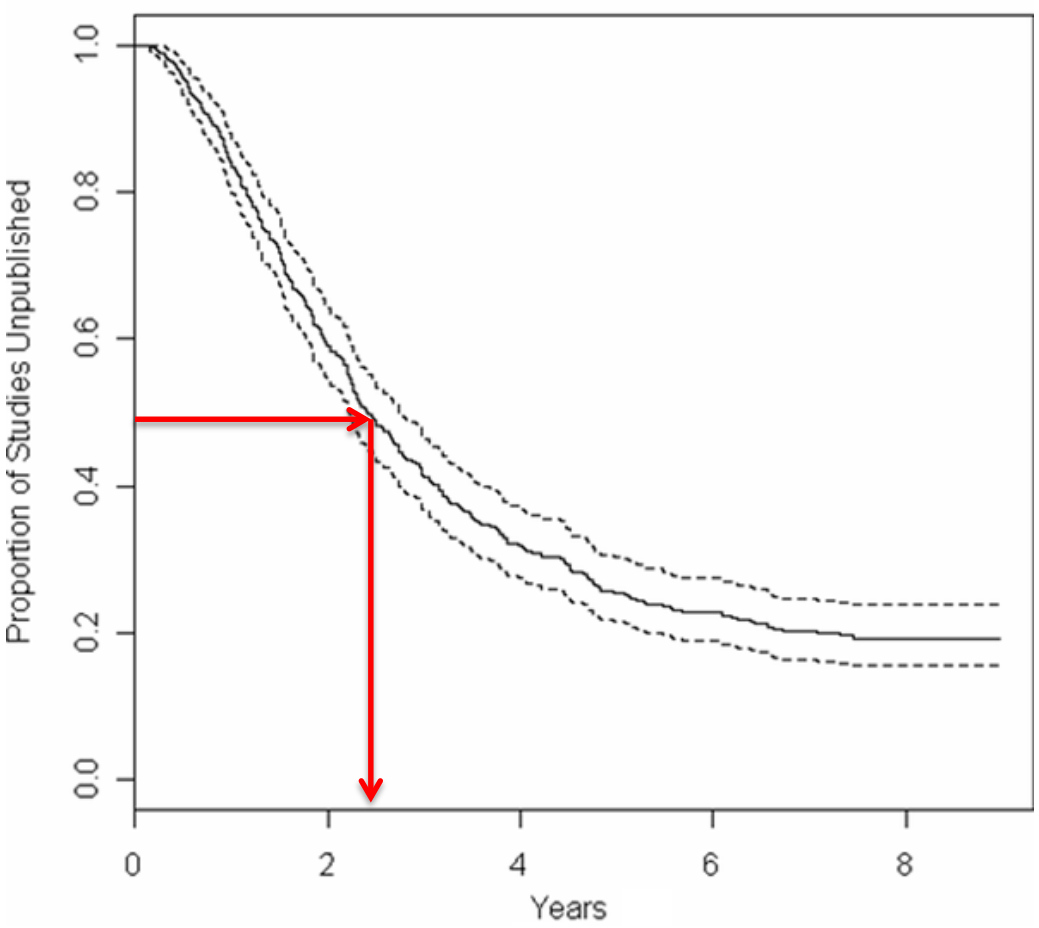
Challenges

1. Inefficiency
2. Poor quality
3. Lack of capacity
4. Lack of investment in information technology
5. Inaccessibility
6. Obsolescence

Time from protocol to SR publication



Tricco, PLoS ONE 2008; 3:e3684

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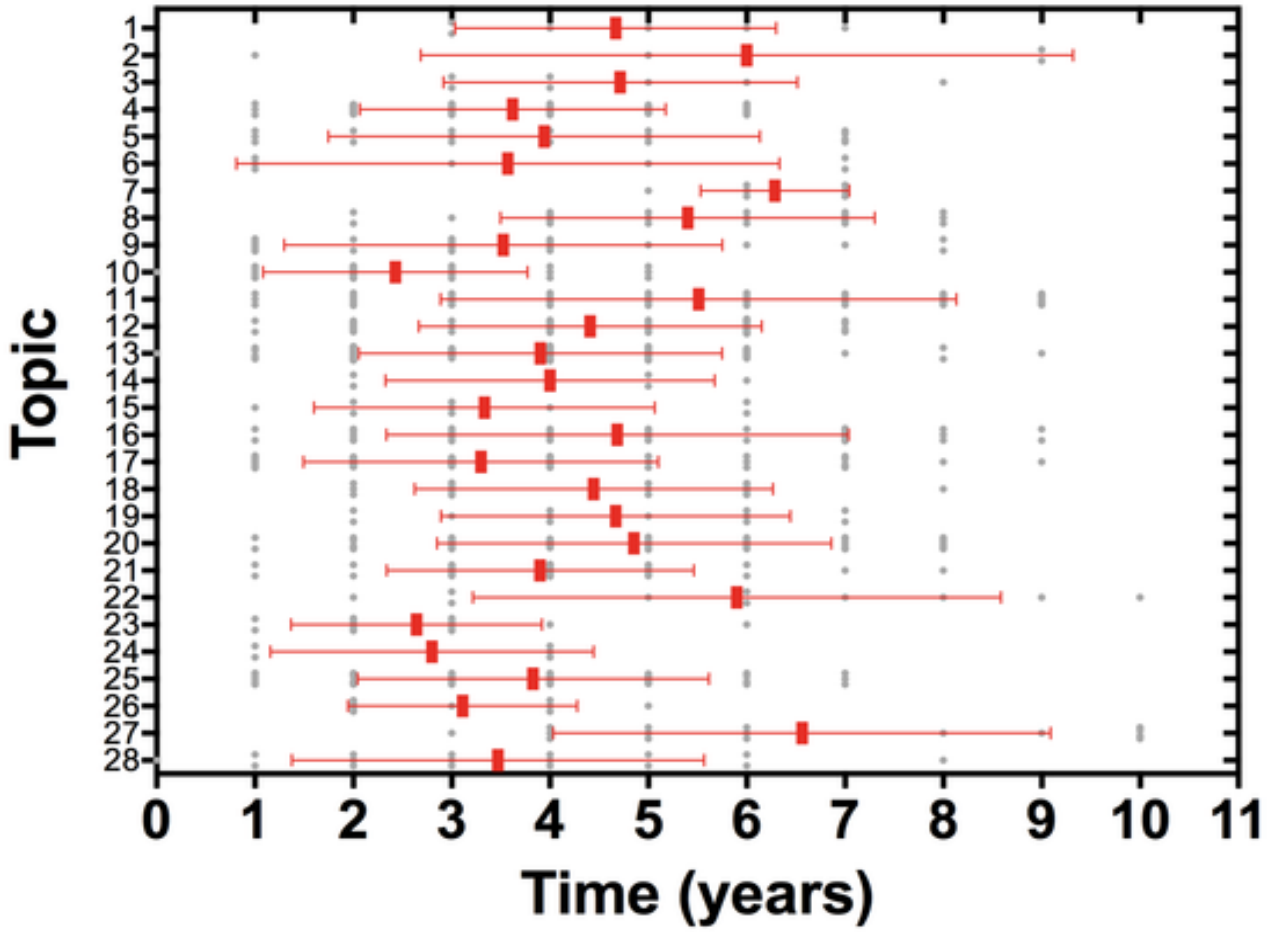
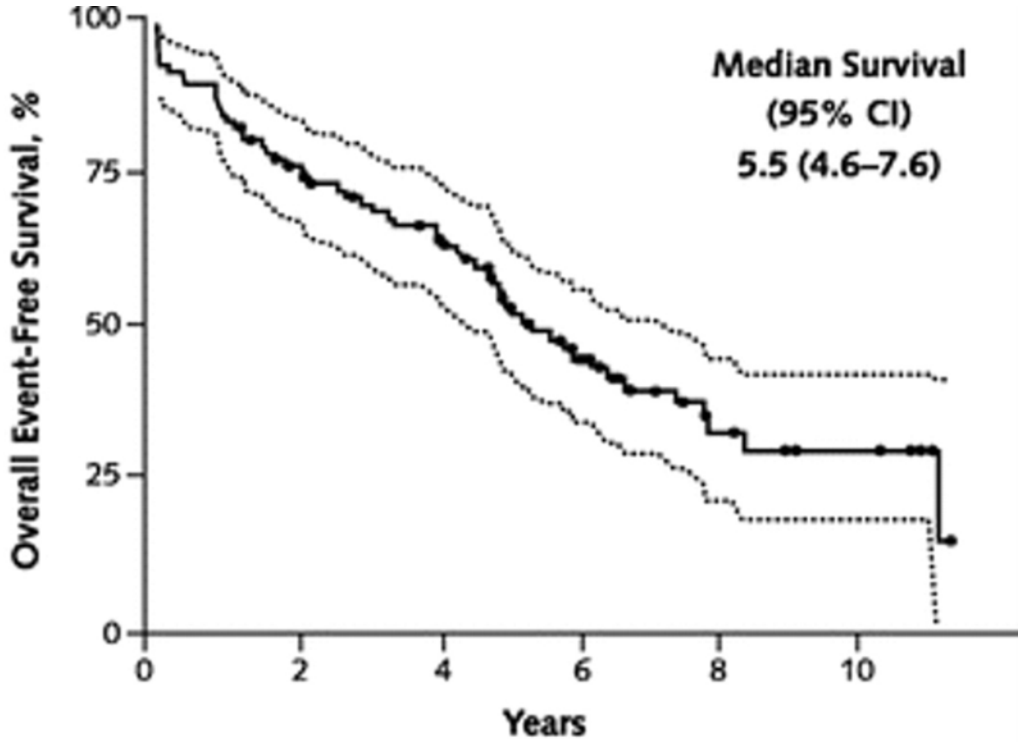
Time from study to systematic review



Elliott JH, Turner T, Clavisi O, Thomas J, et al. (2014) PLoS Med 11(2): e1001603.

Survival of systematic review accuracy



Systematic reviews at risk, *n*	100	73	59	34	14	6

Shojania et al, Ann Intern Med. 2007;147(4):224-233.

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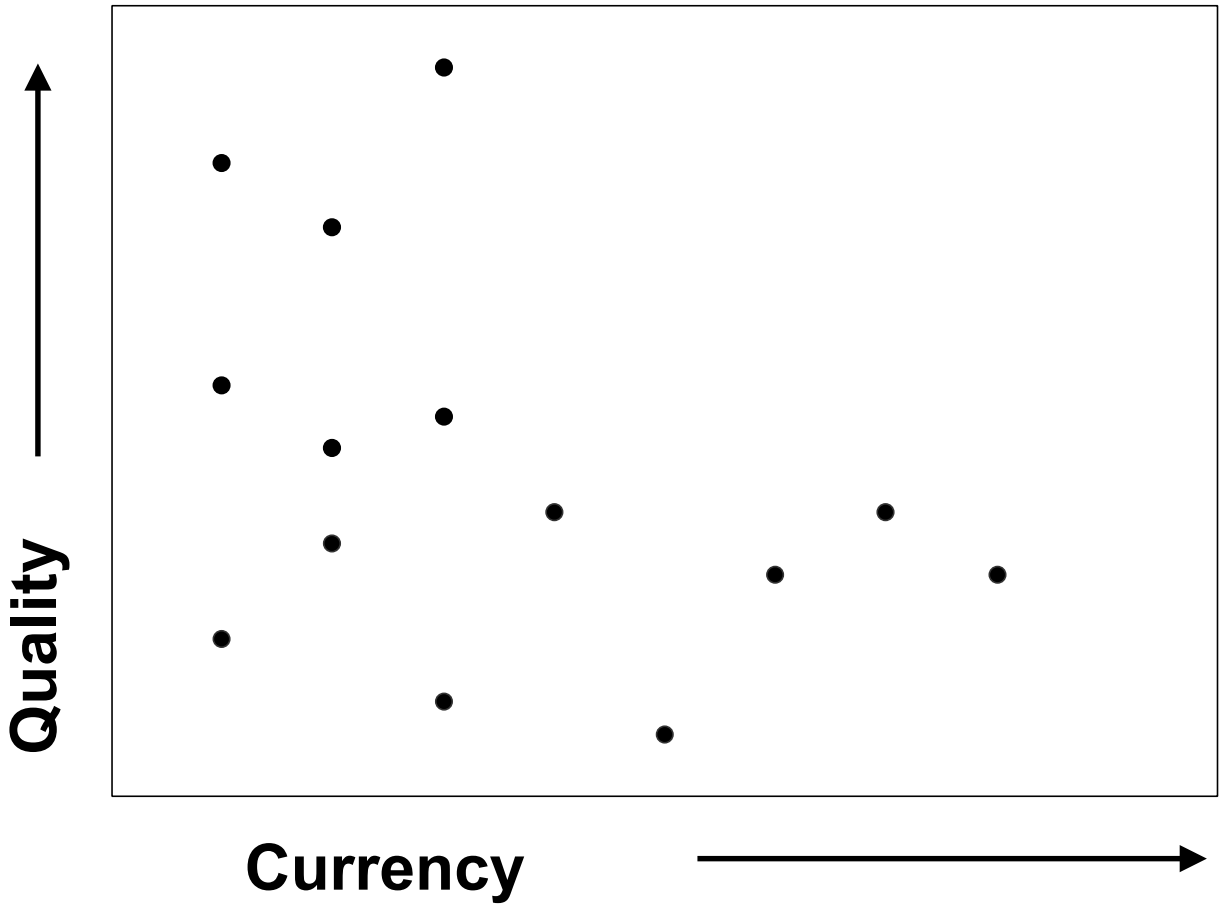
Health evidence trade-off



+AllTrials

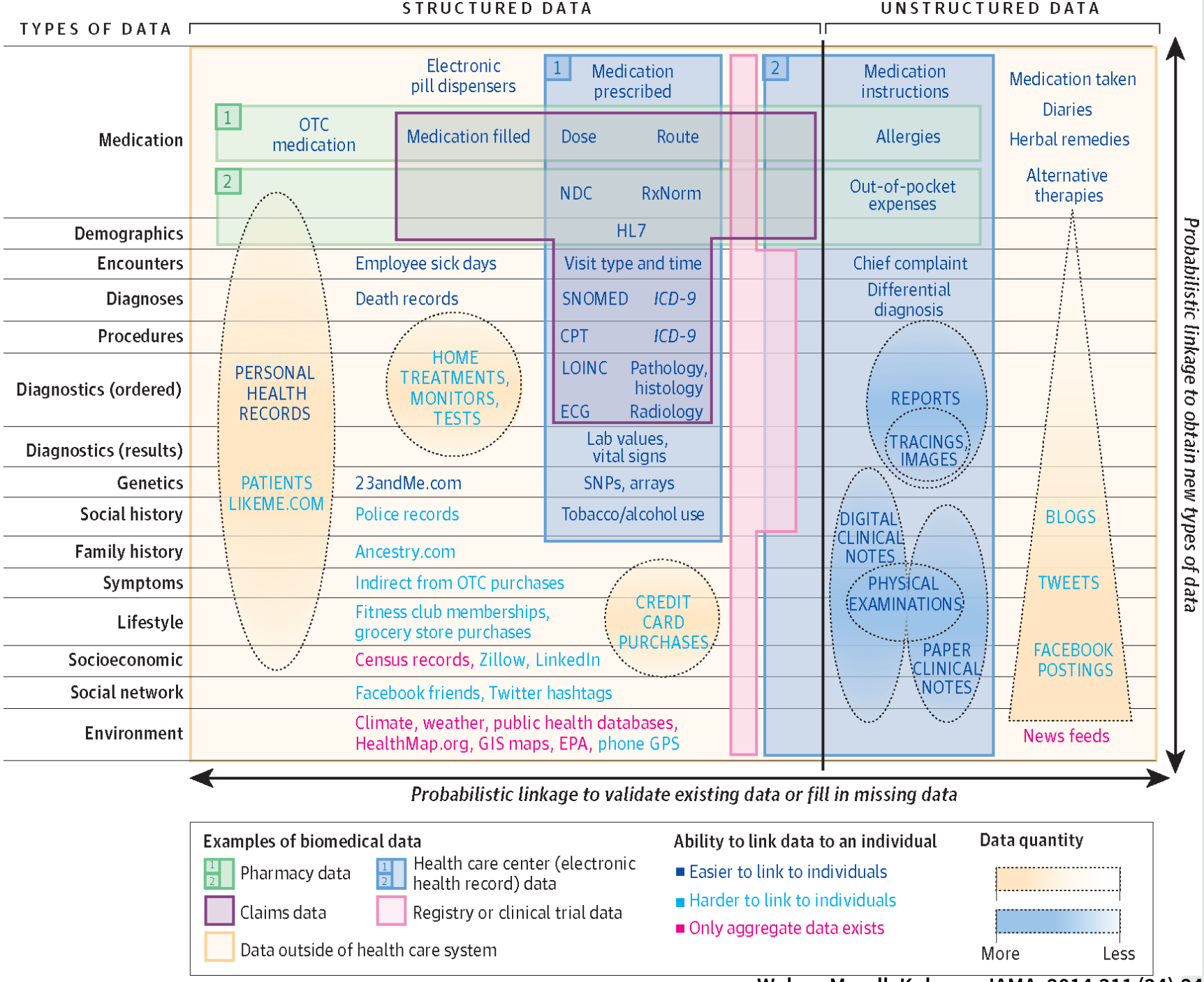
EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Opening up clinical data on new medicines

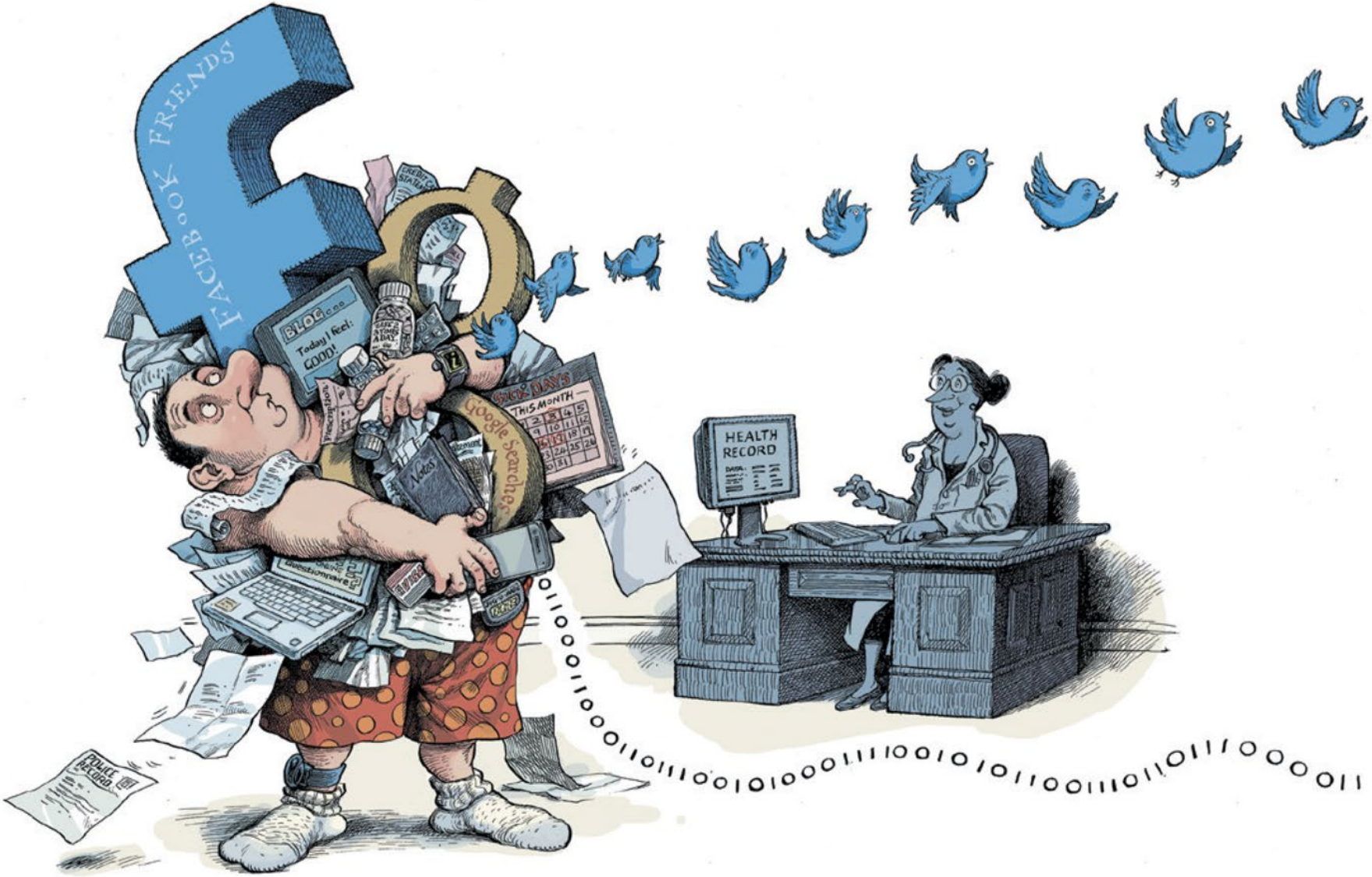
As a first step, EMA is publishing today data for two medicines, representing approximately 260,000 pages of information for over 100 clinical reports. Data will be progressively added online for all applications concerned since the policy entered into force. This will be a learning curve for the Agency and all its stakeholders, as they start

As a first step, EMA is publishing today data for two medicines, representing approximately 260,000 pages of information for over 100 clinical reports.

Once the process is fully implemented and the backlog has been dealt with, EMA aims to publish the reports 60 days after a decision on an application has been taken, or within 150 days after the receipt of the withdrawal letter. EMA is committed to these timelines. However, given the volume of work in publishing these reports, which will have to be undertaken with existing resources, EMA may need to re-assess their feasibility. According to current forecasts, EMA expects to offer access to approximately 4,500 clinical reports per year.



Weber, Mandl, Kohane. JAMA. 2014;311 (24):2479-2480



ILLUSTRATIONS BY DAVID PARKINS

Elliott JH, Griwshaw J, Altman R, et al. Make sense of health data. Nature 2015;527(7576):31-32

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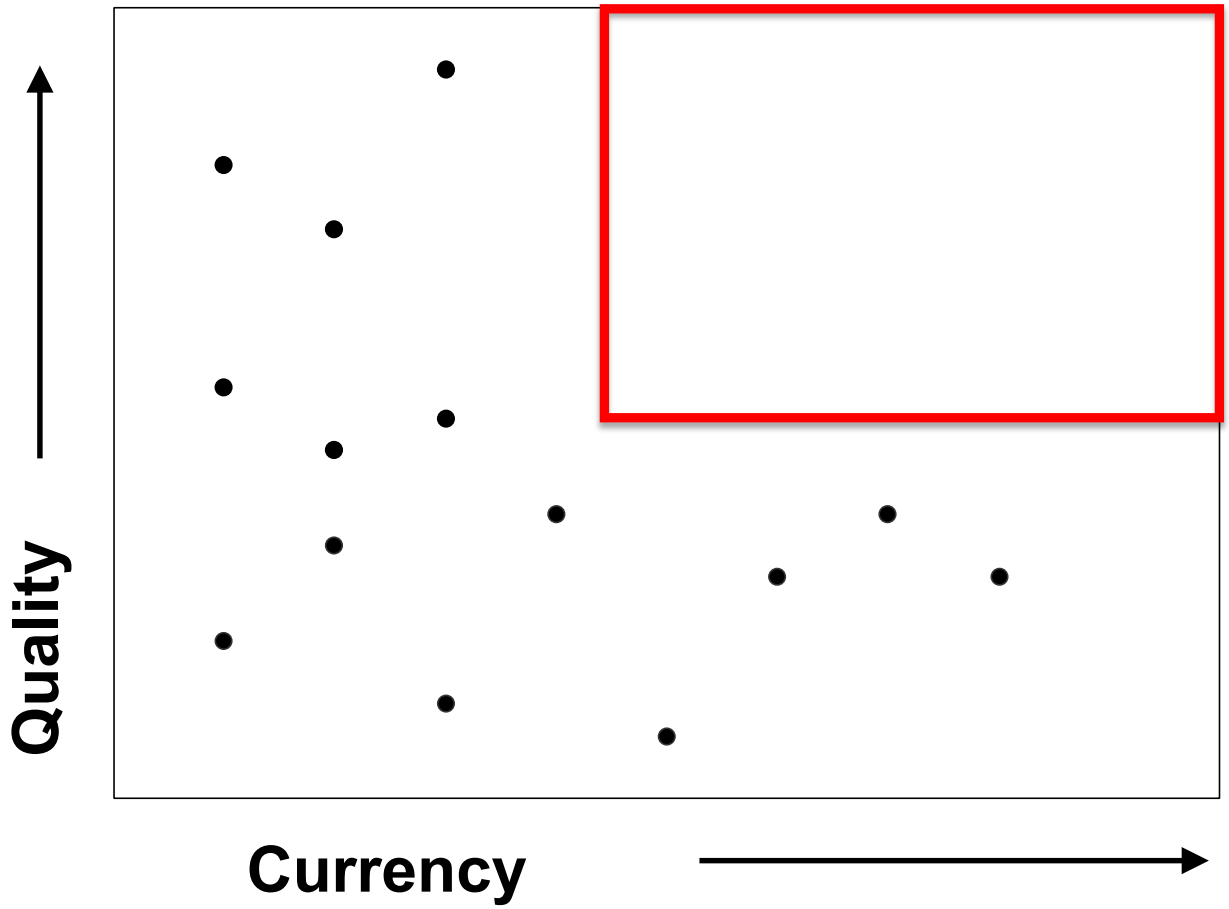
Breaking the health evidence trade-off



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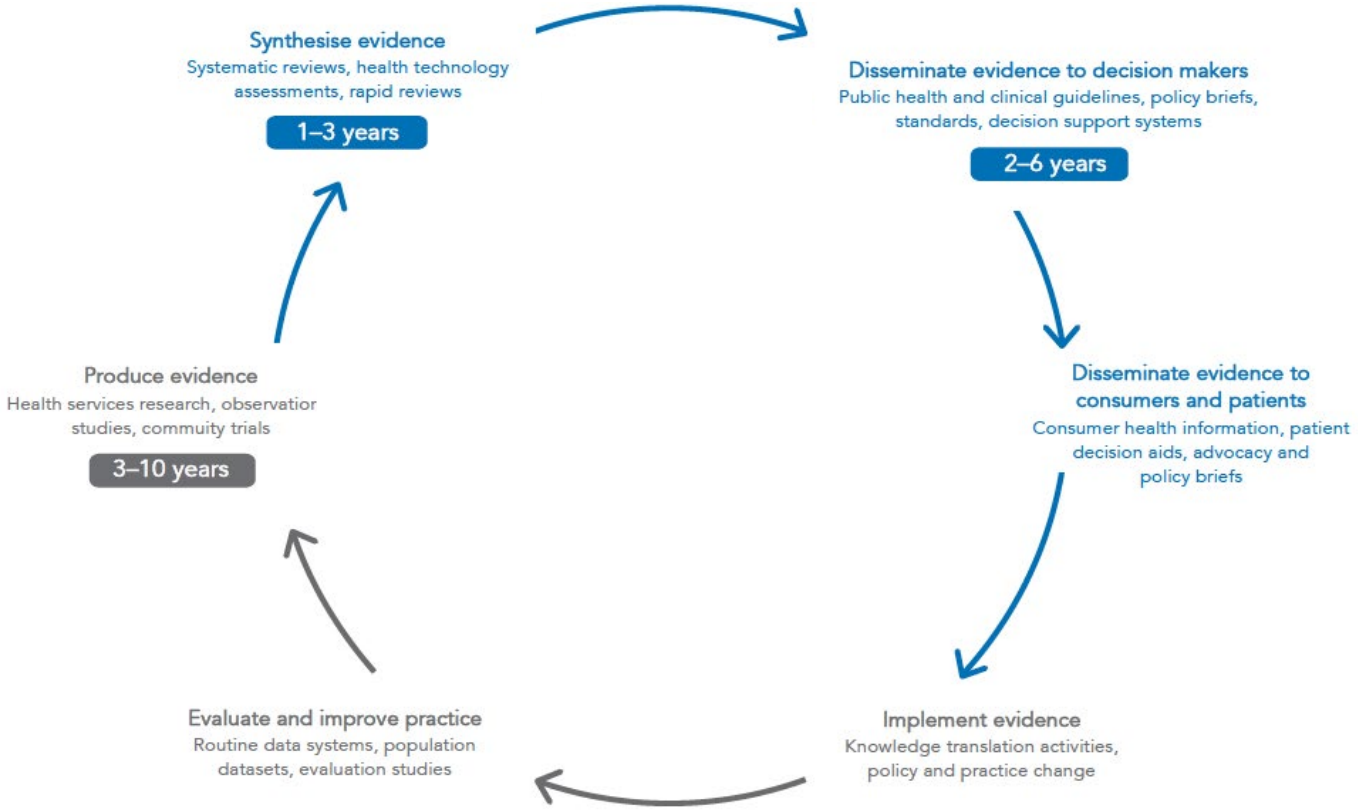
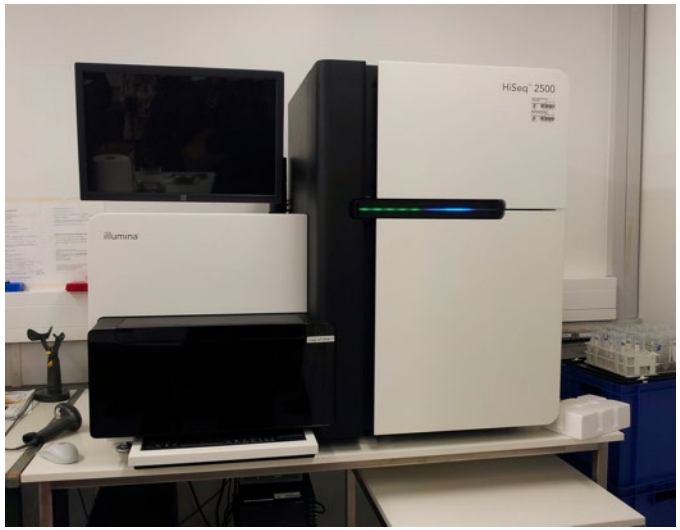
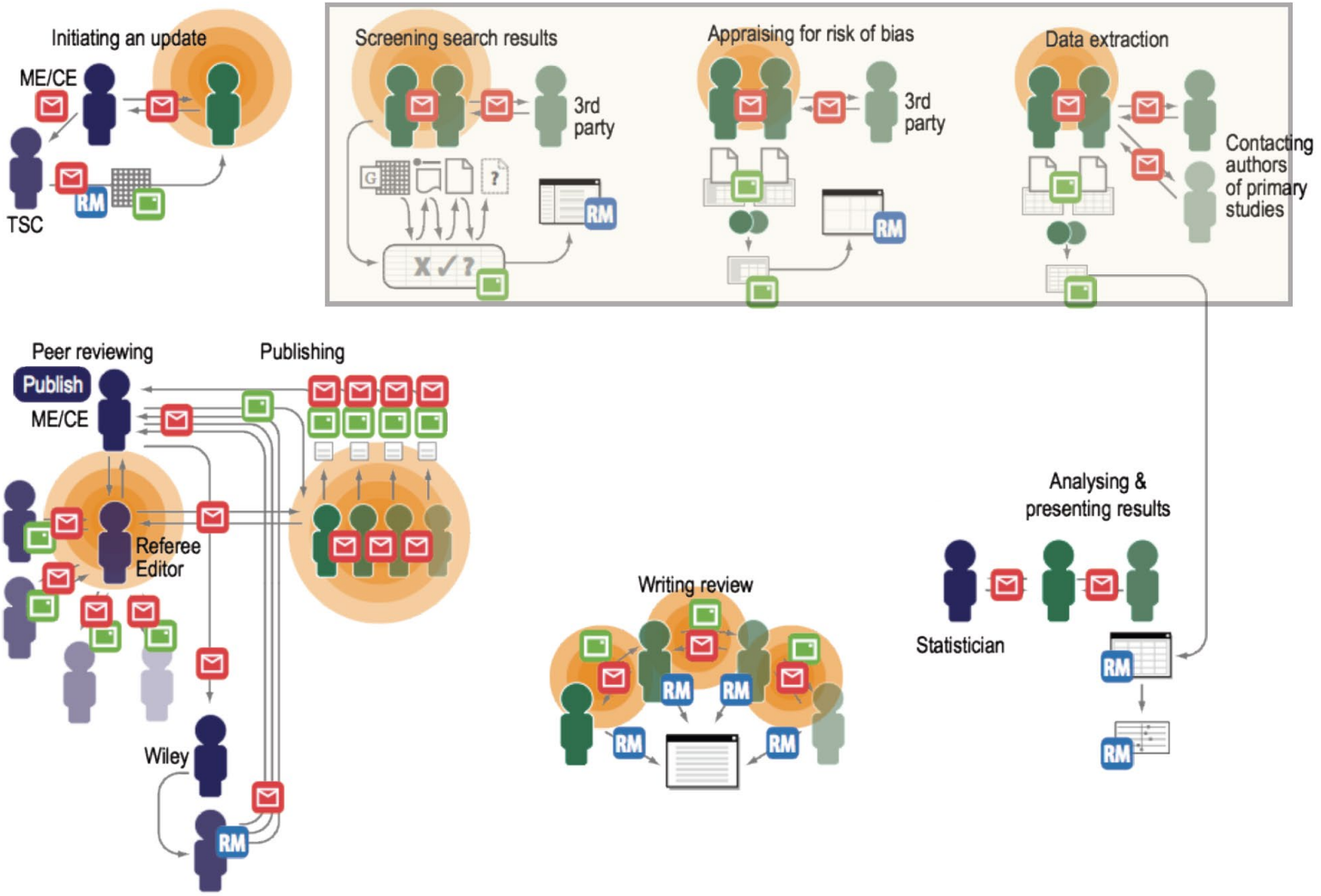
Living Evidence




HiSeq 2500
illumina

Excel, Word, Paper, Email…



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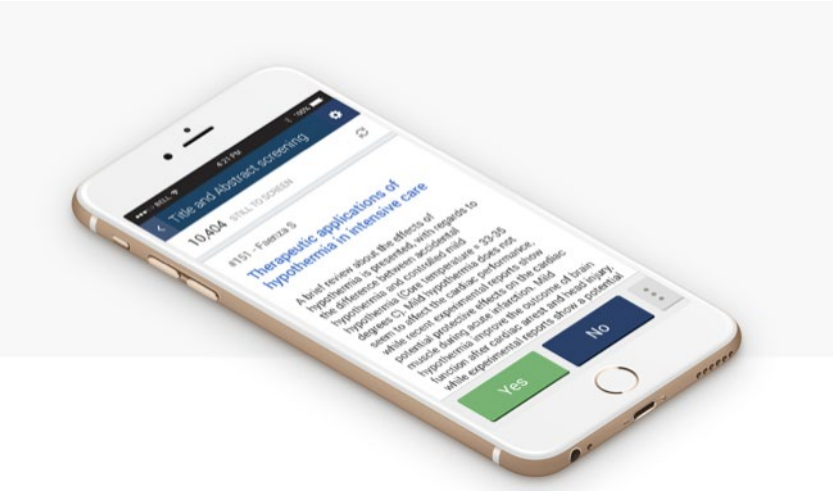
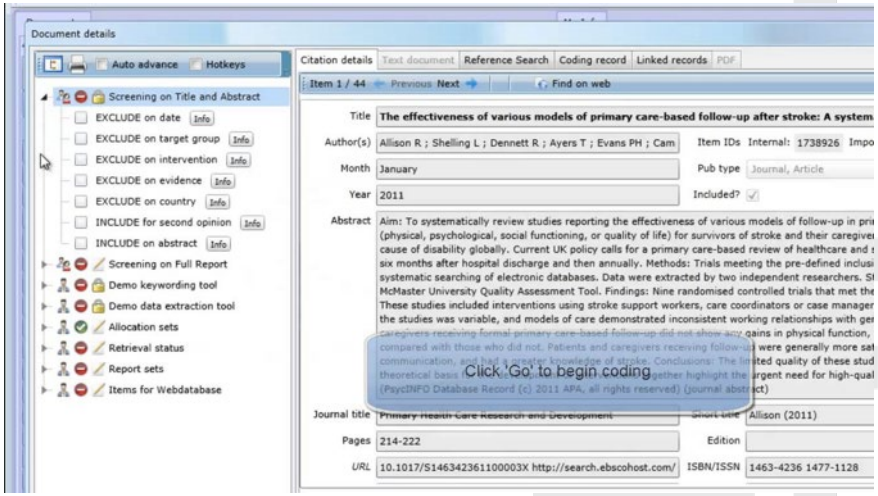
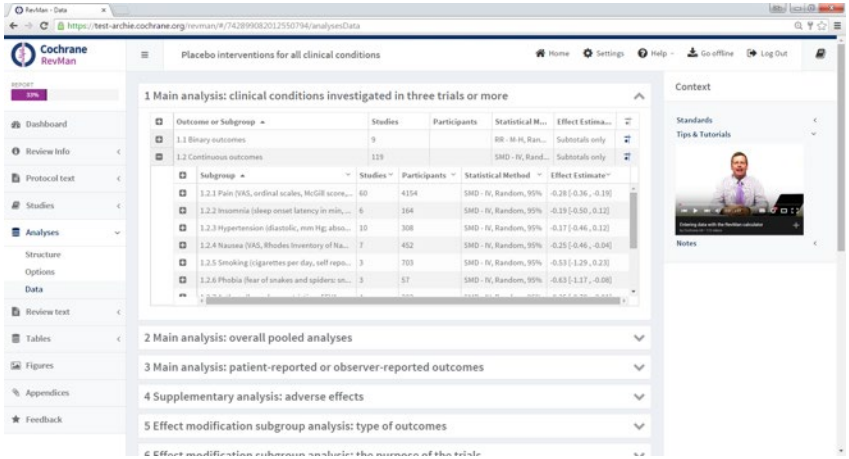
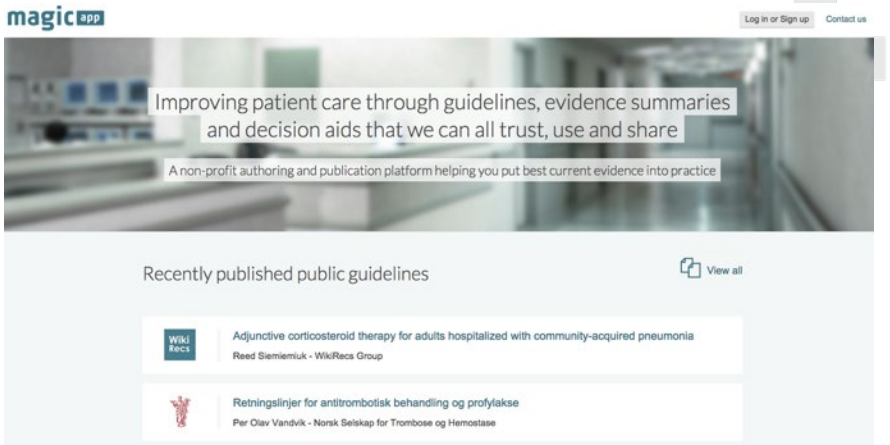
A new software ecosystem









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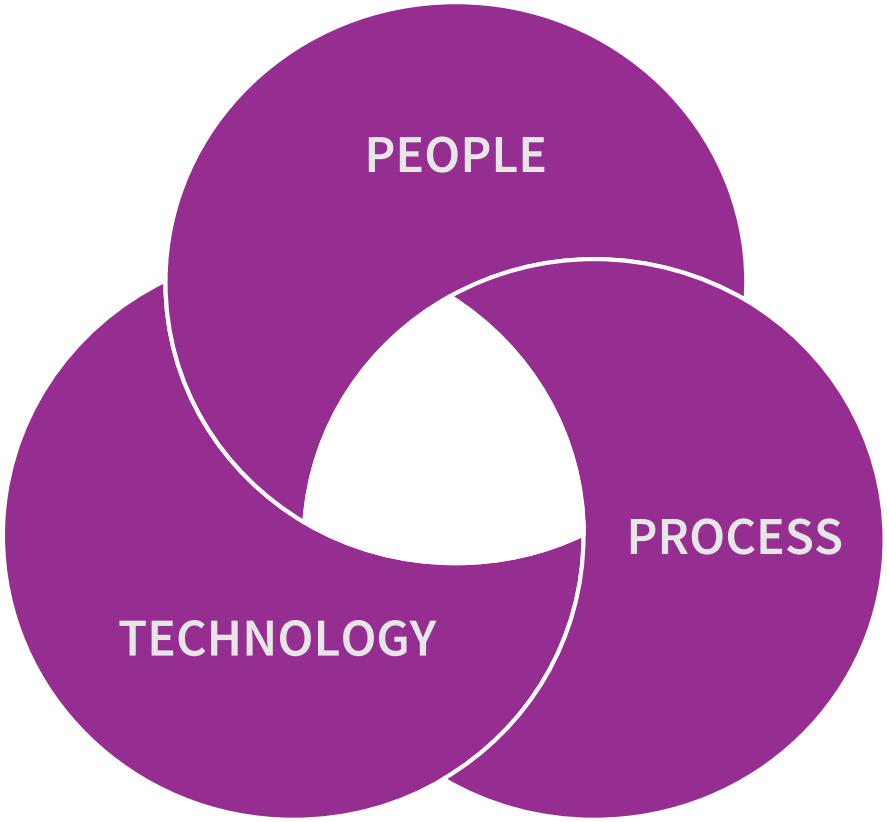
Australian Government
National Health and Medical Research Council

Project Transform



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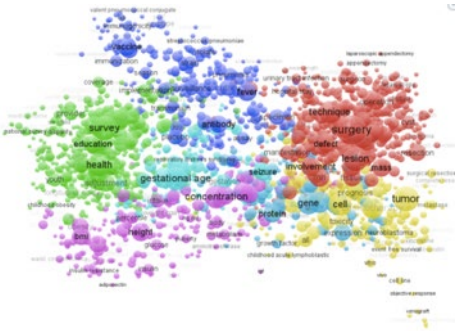
Text mining

Deriving high-quality information from **text**



Machine learning

Models that **learn from data** to make predictions or decisions

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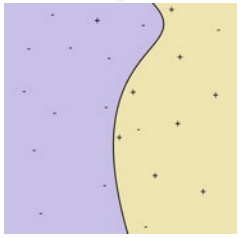
Study 1 Effectiveness of asthma self-care interventions: a systematic review
Study 2 Effectiveness of a self-monitoring asthma intervention: an RCT

RCT?										
0	1	1	1	1	1	1	1	0	0	0
1	1	1	1	0	0	0	0	1	1	1

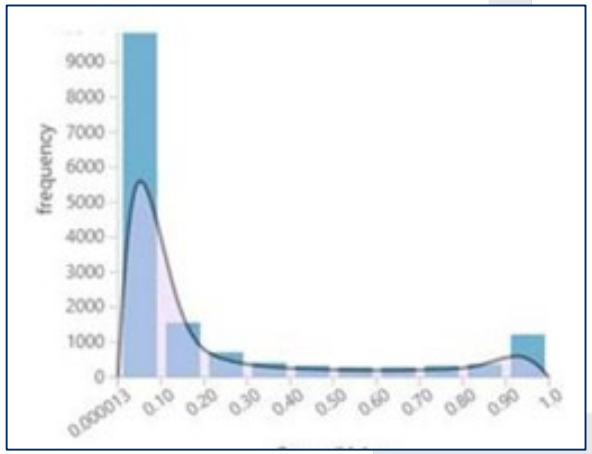


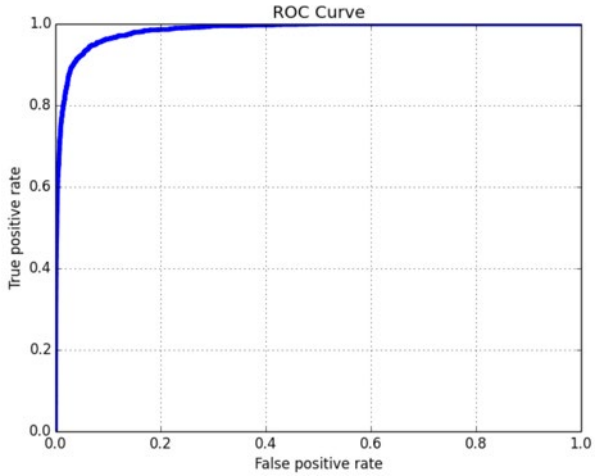
Effectiveness	asthma	self	care	interventions	systematic	review	monitoring	intervention	RCT
1	1	0	0	0	0	0	0	0	1

93%

Study type classification: RCT classifier

- Trained on 400,000 classifications by the Crowd; calibrated on 49,000 studies in McMaster ‘Hedges’ dataset; tested against all included studies in Cochrane reviews (94,000)
- Provides a score for each citation (0-100)
- Recall of 99.8%
- Generalises across reviews





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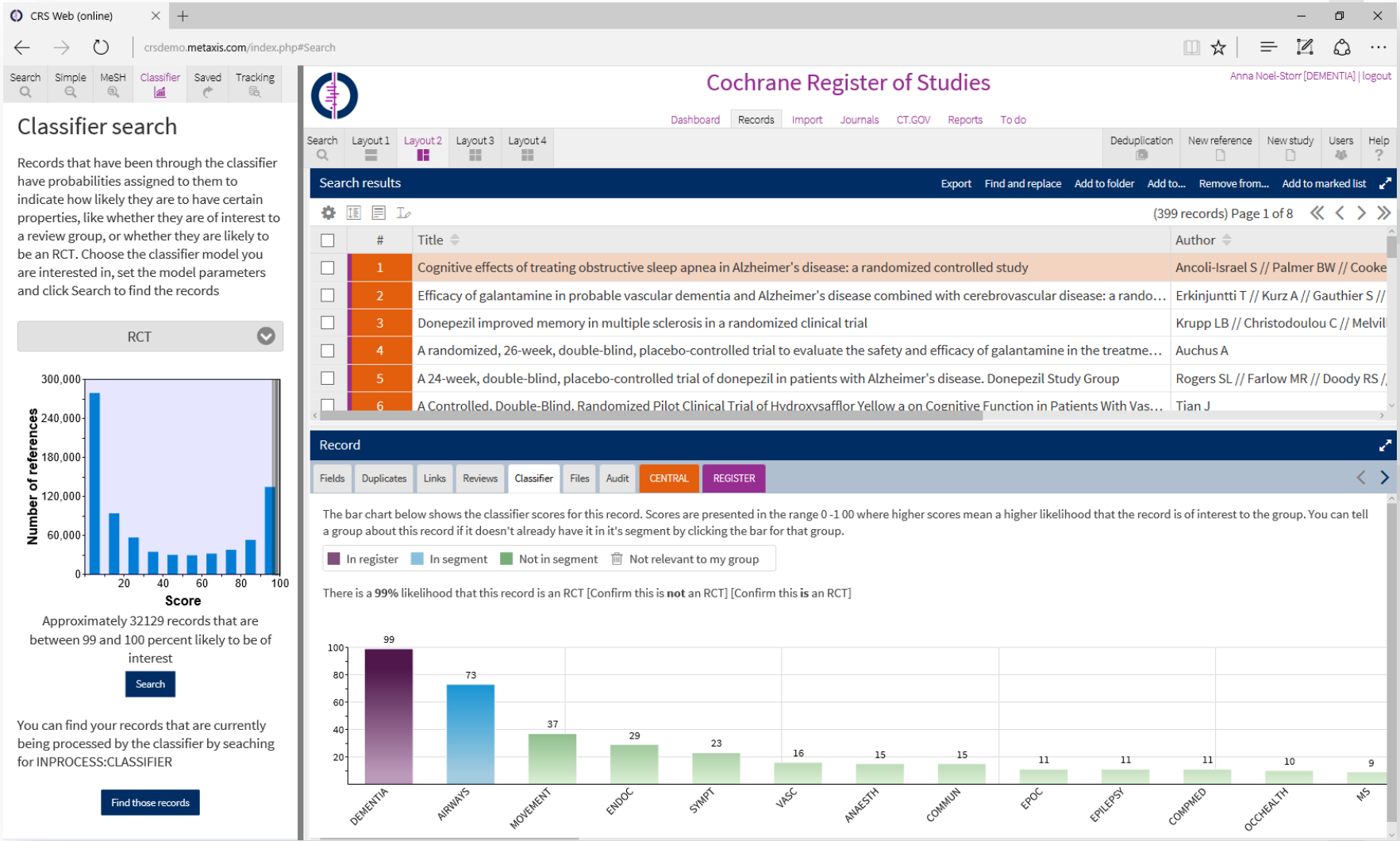
Deployed



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Systematic Review Accelerator

- Dashboard
- Polyglot Search
- SRA-Helper
- RevMan Replicant
- My libraries
- Library tools
- Help
- Recommended Tools
- Whats new
- About Us
- Contact Us

Help

Help Topics

- Importing / Exporting Libraries
- DeDuplicator
- DeDuplicator (Offline)
- Word Frequency Analyser
- Polyglot Search Syntax Translator

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Give it a try

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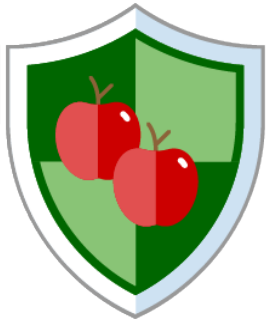
Micro-training modules

Treatments can harm

Anecdotes are unreliable

Expert opinion alone is not enough

The role of comparison



Comparing like with like

The role of blinding

Size matters

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Is this an RCT?

The efficacy of internet-based cognitive behavioral therapy for insomnia. [Chinese] [609918800]

Objective To evaluate the effectiveness of internet-based cognitive behavioral therapy (ICBT) for the treatment of insomnia by comparison of sleep parameters, degrees of anxiety and depression of the ICBT, with traditional face-to-face cognitive behavioral therapy (CBT) and pharmacotherapy for insomnia. Methods Seventy-nine cases meeting proposed DSM-5 criteria for insomnia disorder were randomly assigned to ICBT (n=27), CBT (n=26), and pharmacotherapy (n=26) group, and treated accordingly for 8 consecutive weeks. The sleep parameters, the levels of anxiety and depression in the 3 groups were compared and analyzed before, 4 weeks after and the termination of treatment. Results Comparing to that of pre-treatment, the sleep parameters were significantly improved, anxiety and depression levels obviously decreased after treatment for 4 and 8 consecutive weeks, the differences were statistically significant (P<0.05). After treatment for 4 consecutive weeks, the sleep latency, total asleep time and wake time after sleep were significantly different (P<0.05) when compared with pharmacotherapy group with ICBT and CBT groups. After the treatment, the sleep latency, anxiety and depression levels were lower in ICBT and CBT groups than those in pharmacotherapy group, and the difference was statistically significant (P<0.05). In addition, no significant difference (P>0.05) was found in sleep parameters and anxiety level between ICBT group and CBT group. Conclusion ICBT may display a slower effect on improving speed in falling asleep than the pharmacotherapy does, but the efficacy of ICBT is better than that of pharmacotherapy after

RCT/CCT

Reject

Unsure

Help me decide

Add a note

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13,757
contributors

3,270,774
classifications

80,000+
RCTs/q-RCTs

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Accuracy

	Info specialist and methodologist	
Cochrane citizen scientists	True positives 457	False positives 58
	False negatives 4	True negatives 5522

Sensitivity: 99.1% **Specificity: 99.0%**

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Efficiency

N = 3635 RCT = 872	N = 4913 RCT = 831	N = 1200 RCT = 370	N = 3424 RCT = 1446
54	64	29	47
1 day	3 days	4.5 hrs	5 days
76% reduction	83% reduction	69% reduction	58% reduction

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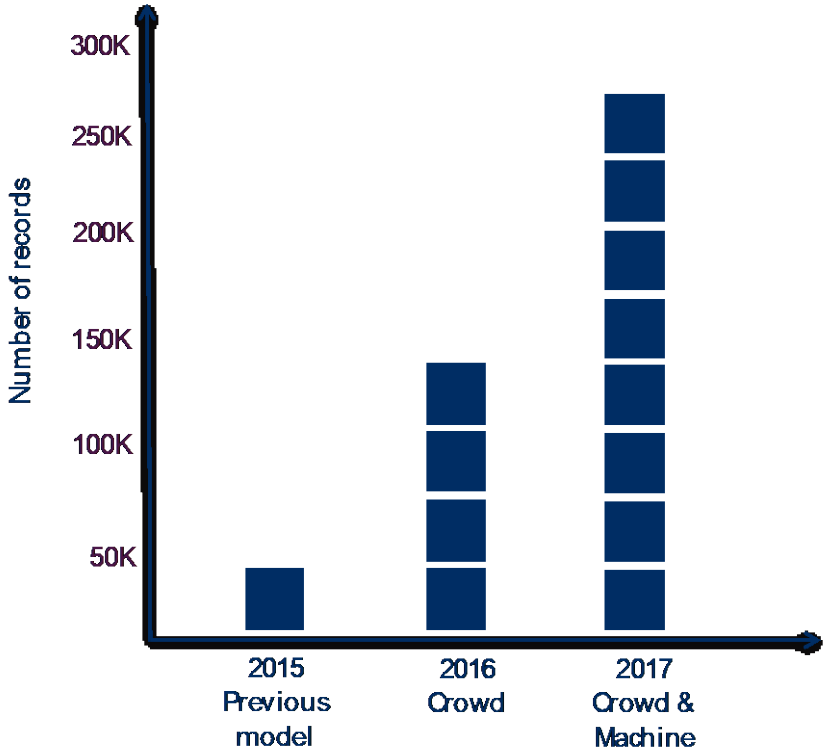
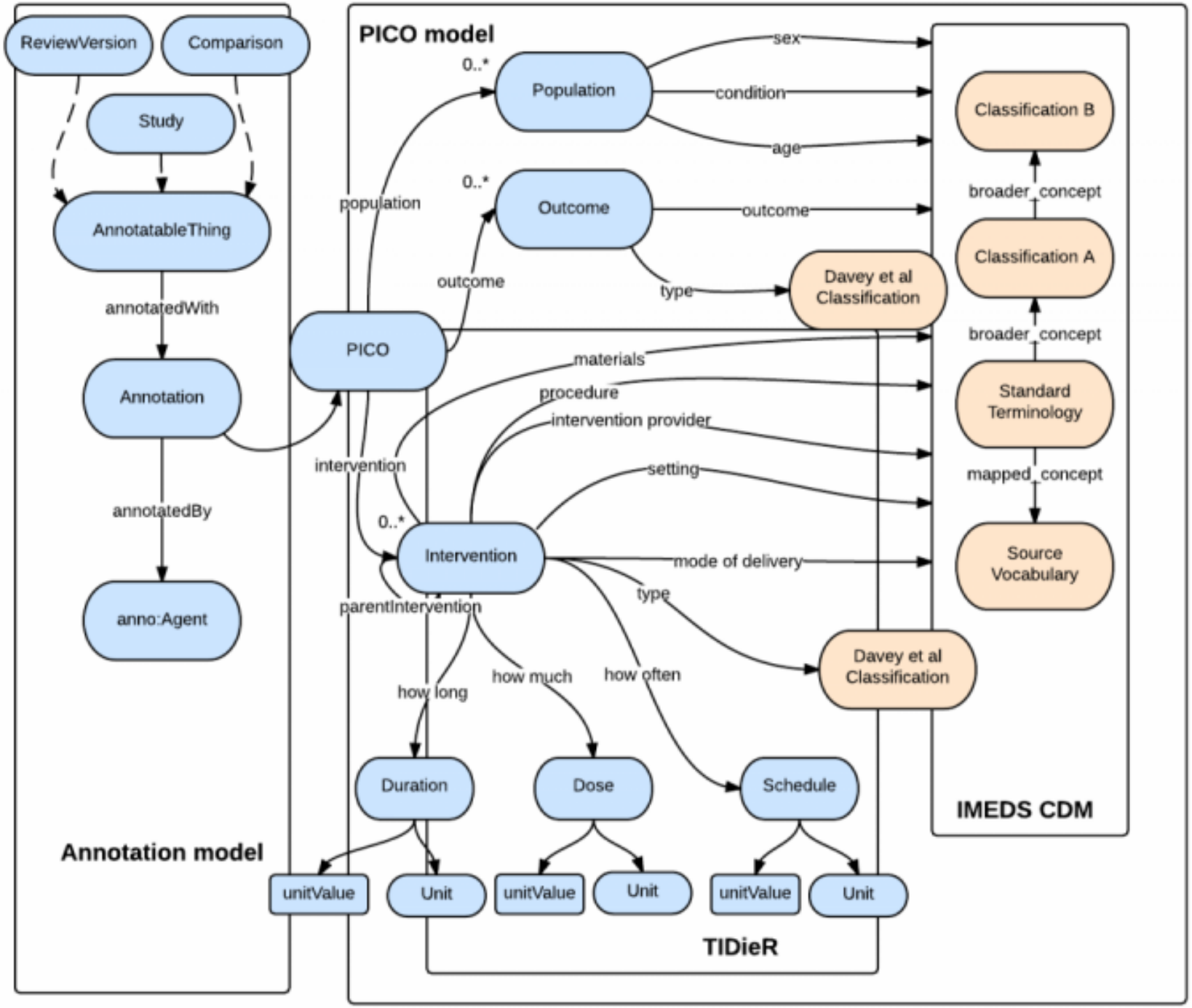
Throughput

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Classification B
broader_concept
Classification A
broader_concept
Standard Terminology
mapped_concept
Source Vocabulary
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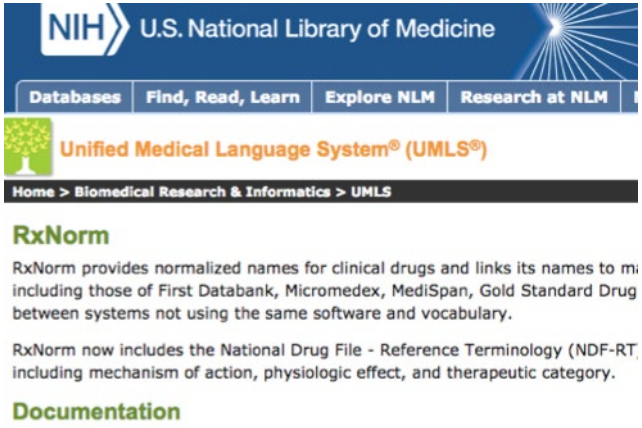
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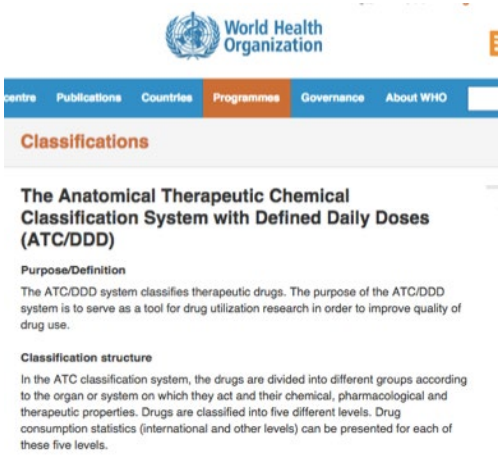
RxNorm
RxNorm provides normalized names for clinical drugs and links its names to m
including those of First Databank, Micromedex, MediSpan, Gold Standard Drug
between systems not using the same software and vocabulary.
RxNorm now includes the National Drug File - Reference Terminology (NDF-RT
including mechanism of action, physiologic effect, and therapeutic category.
Documentation


World Health Organization
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Programmes
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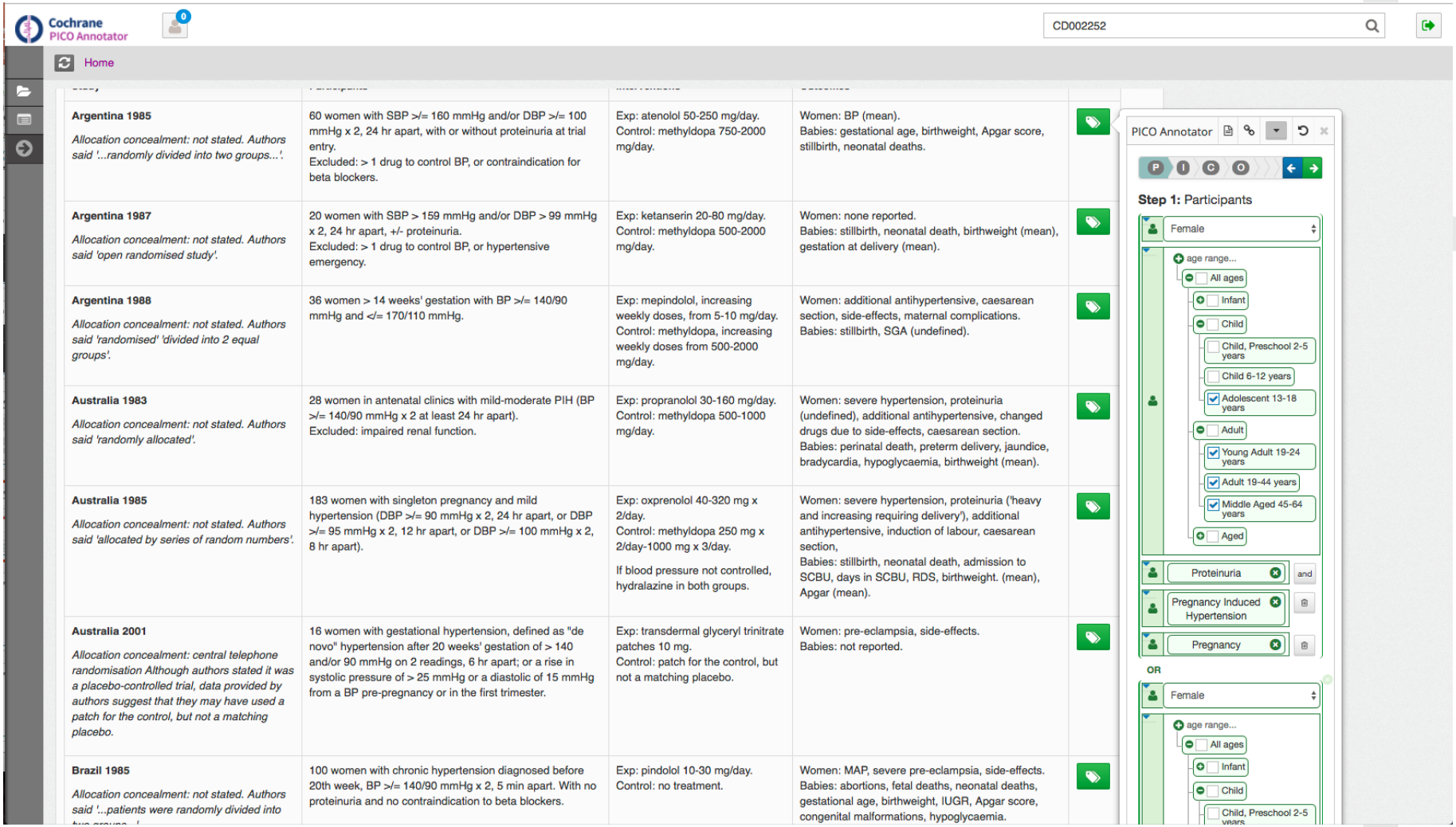
About WHO
Classifications
The Anatomical Therapeutic Chemical Classification System with Defined Daily Doses (ATC/DDD)
Purpose/Definition
The ATC/DDD system classifies therapeutic drugs. The purpose of the ATC/DDD system is to serve as a tool for drug utilization research in order to improve quality of drug use.
Classification structure
In the ATC classification system, the drugs are divided into different groups according to the organ or system on which they act and their chemical, pharmacological and therapeutic properties. Drugs are classified into five different levels. Drug consumption statistics (international and other levels) can be presented for each of these five levels.

PICO Annotator



Argentina 1985 *Allocation concealment: not stated. Authors said '...randomly divided into two groups...'.*	60 women with SBP >/= 160 mmHg and/or DBP >/= 100 mmHg x 2, 24 hr apart, with or without proteinuria at trial entry. Excluded: > 1 drug to control BP, or contraindication for beta blockers.	Exp: atenolol 50-250 mg/day. Control: methyldopa 750-2000 mg/day.	Women: BP (mean). Babies: gestational age, birthweight, Apgar score, stillbirth, neonatal deaths.
Argentina 1987 *Allocation concealment: not stated. Authors said 'open randomised study'.*	20 women with SBP > 159 mmHg and/or DBP > 99 mmHg x 2, 24 hr apart, +/- proteinuria. Excluded: > 1 drug to control BP, or hypertensive emergency.	Exp: ketanserin 20-80 mg/day. Control: methyldopa 500-2000 mg/day.	Women: none reported. Babies: stillbirth, neonatal death, birthweight (mean), gestation at delivery (mean).
Argentina 1988 *Allocation concealment: not stated. Authors said 'randomised' 'divided into 2 equal groups'.*	36 women > 14 weeks' gestation with BP >/= 140/90 mmHg and </= 170/110 mmHg.	Exp: mepindolol, increasing weekly doses, from 5-10 mg/day. Control: methyldopa, increasing weekly doses from 500-2000 mg/day.	Women: additional antihypertensive, caesarean section, side-effects, maternal complications. Babies: stillbirth, SGA (undefined).
Australia 1983 *Allocation concealment: not stated. Authors said 'randomly allocated'.*	28 women in antenatal clinics with mild-moderate PIH (BP >/= 140/90 mmHg x 2 at least 24 hr apart). Excluded: impaired renal function.	Exp: propranolol 30-160 mg/day. Control: methyldopa 500-1000 mg/day.	Women: severe hypertension, proteinuria (undefined), additional antihypertensive, changed drugs due to side-effects, caesarean section. Babies: perinatal death, preterm delivery, jaundice, bradycardia, hypoglycaemia, birthweight (mean).
Australia 1985 *Allocation concealment: not stated. Authors said 'allocated by series of random numbers'.*	183 women with singleton pregnancy and mild hypertension (DBP >/= 90 mmHg x 2, 24 hr apart, or DBP >/= 95 mmHg x 2, 12 hr apart, or DBP >/= 100 mmHg x 2, 8 hr apart).	Exp: oxprenolol 40-320 mg x 2/day. Control: methyldopa 250 mg x 2/day-1000 mg x 3/day. If blood pressure not controlled, hydralazine in both groups.	Women: severe hypertension, proteinuria ('heavy and increasing requiring delivery'), additional antihypertensive, induction of labour, caesarean section, Babies: stillbirth, neonatal death, admission to SCBU, days in SCBU, RDS, birthweight. (mean), Apgar (mean).
Australia 2001 *Allocation concealment: central telephone randomisation Although authors stated it was a placebo-controlled trial, data provided by authors suggest that they may have used a patch for the control, but not a matching placebo.*	16 women with gestational hypertension, defined as "de novo" hypertension after 20 weeks' gestation of > 140 and/or 90 mmHg on 2 readings, 6 hr apart; or a rise in systolic pressure of > 25 mmHg or a diastolic of 15 mmHg from a BP pre-pregnancy or in the first trimester.	Exp: transdermal glyceryl trinitrate patches 10 mg. Control: patch for the control, but not a matching placebo.	Women: pre-eclampsia, side-effects. Babies: not reported.
Brazil 1985 *Allocation concealment: not stated. Authors said '...patients were randomly divided into*	100 women with chronic hypertension diagnosed before 20th week, BP >/= 140/90 mmHg x 2, 5 min apart. With no proteinuria and no contraindication to beta blockers.	Exp: pindolol 10-30 mg/day. Control: no treatment.	Women: MAP, severe pre-eclampsia, side-effects. Babies: abortions, fetal deaths, neonatal deaths, gestational age, birthweight, IUGR, Apgar score, congenital malformations, hypoglycaemia.

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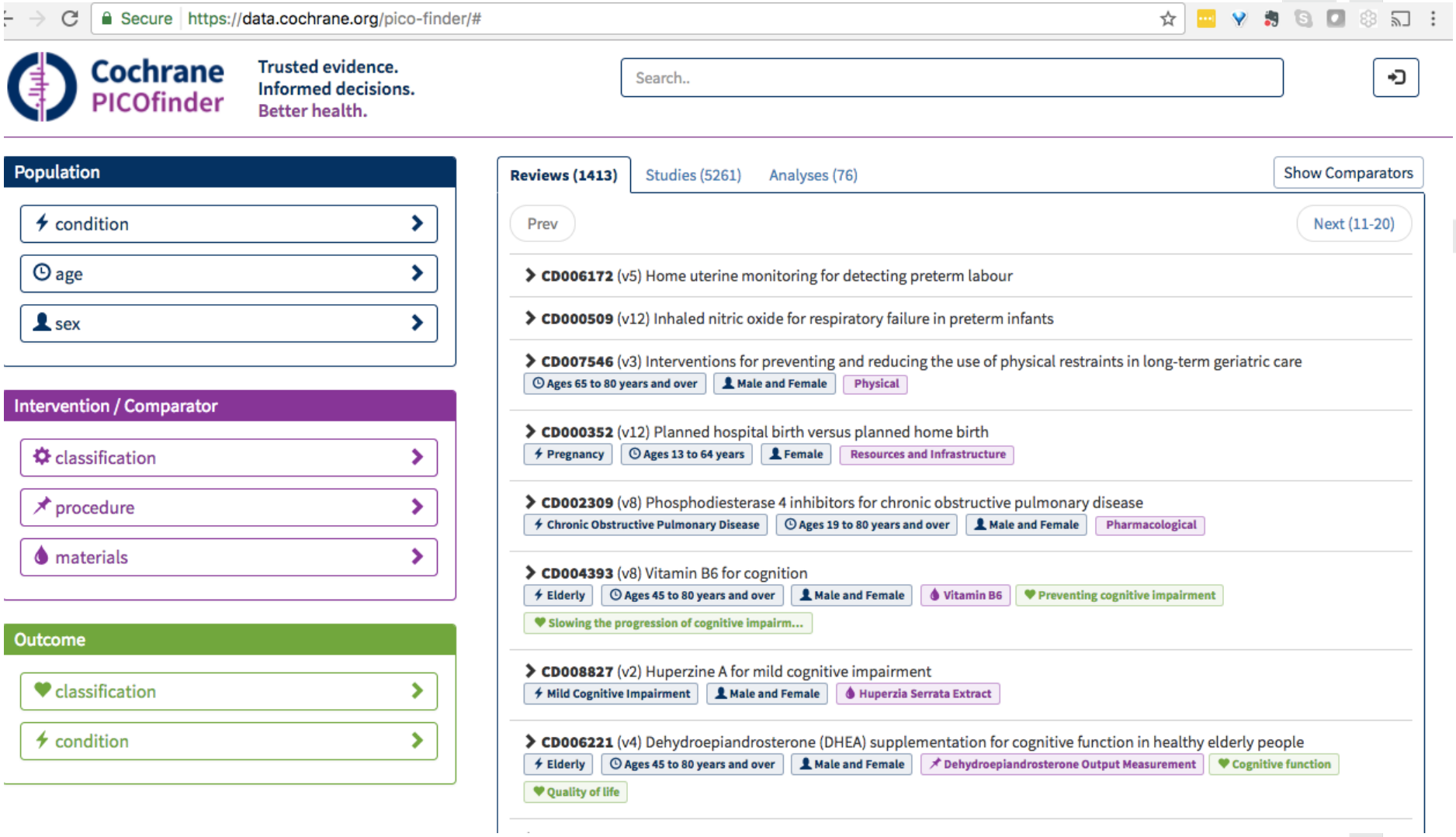
Exploring content

Flexible search for combinations of Population, Intervention, Outcome



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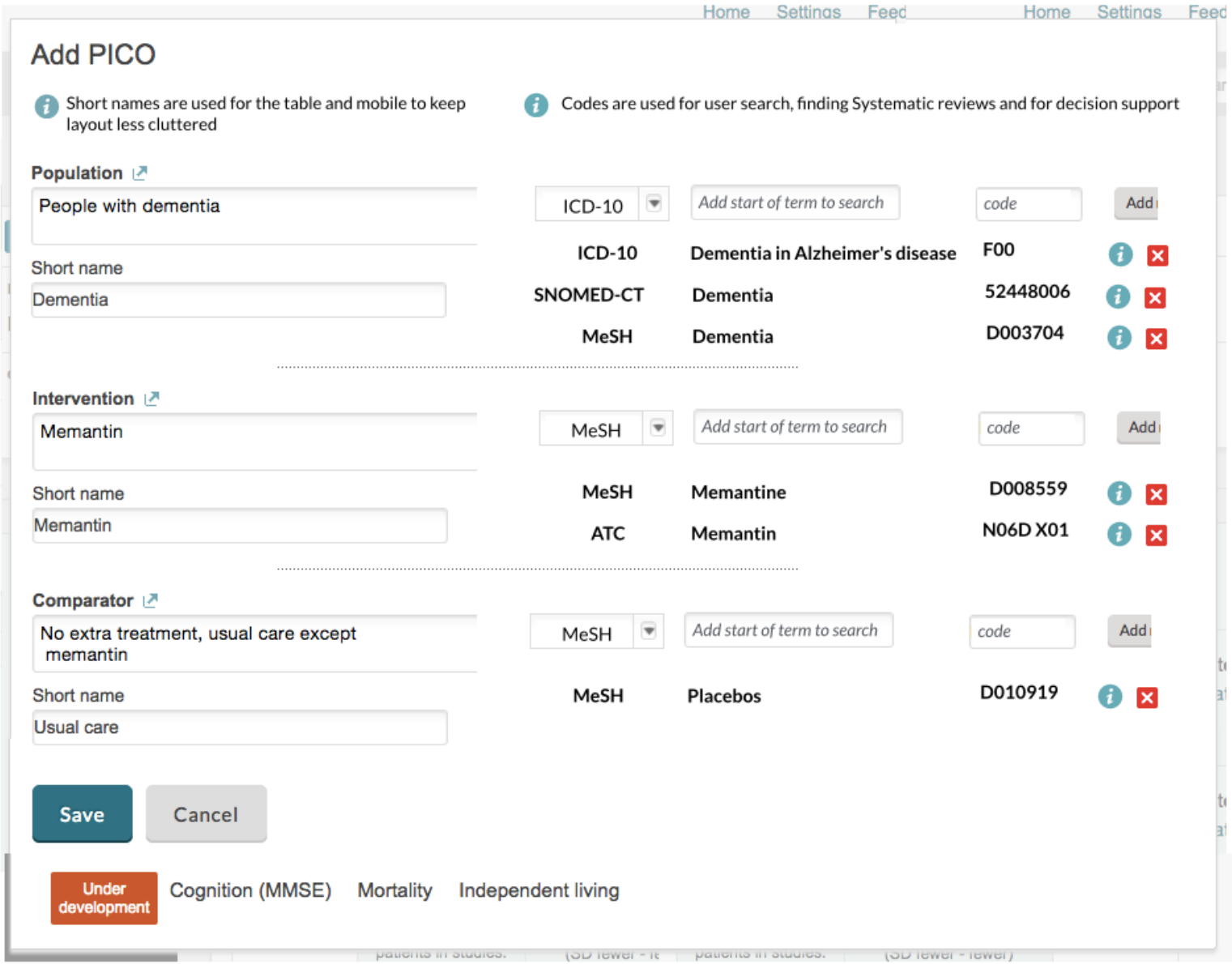
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Add PICO
Short names are used for the table and mobile to keep layout less cluttered
Codes are used for user search, finding Systematic reviews and for decision support
Population
People with dementia
Short name
Dementia
ICD-10
Add start of term to search
code
Add
ICD-10 Dementia in Alzheimer's disease F00
SNOMED-CT Dementia 52448006
MeSH Dementia D003704
Intervention
Memantin
Short name
Memantin
MeSH
Add start of term to search
code
Add
MeSH Memantine D008559
ATC Memantin N06D X01
Comparator
No extra treatment, usual care except memantin
Short name
Usual care
MeSH
Add start of term to search
code
Add
MeSH Placebos D010919
Save
Cancel
Under development
Cognition (MMSE)
Mortality
Independent living

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Develop recommendations

Children 1 month to 2 years old receiving antibiotics for an infection.

Strong recommendation

Benefits clearly outweigh the drawbacks/harms.

We recommend adjunctive probiotics rather than no probiotics.

VIEW LESS DETAILS

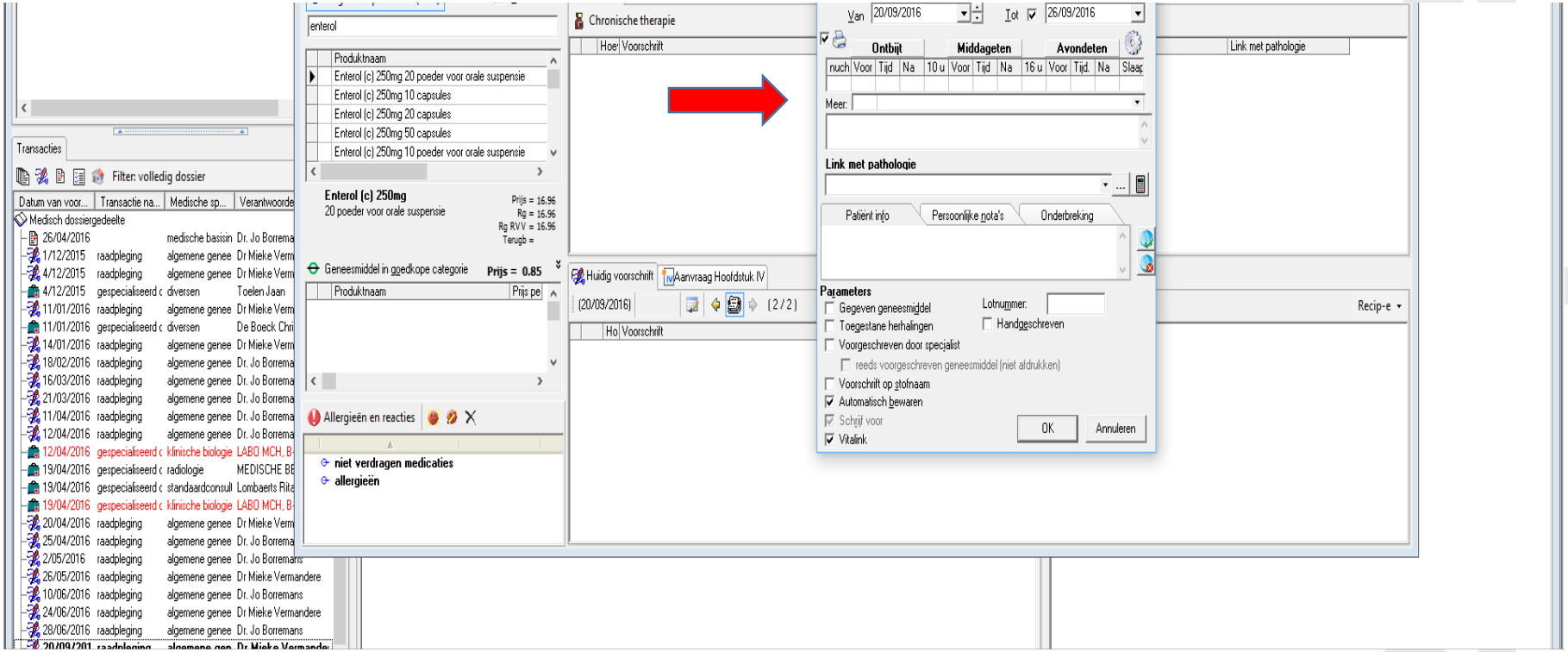
Research evidence | Key info | Rationale | Practical info | Adaptation | Decision Aids | Feedback (0)

Population	Intervention	Comparator
Children 1 month to 2 years old View	Adjunctive probiotic therapy	No probiotic therapy

Evidence profile | Summary | References

Outcome Timeframe	Study results and measurements	Absolute effect estimates No probiotics	 Probiotics	Certainty in effect estimates (Quality of evidence)	Summary
AAD <2 years	Relative risk 0.46 (CI 95% 0.35 - 0.61) Based on data from 3898 patients in 22 studies Follow up: 1-12 weeks.	180 per 1000	83 per 1000 Difference: 97 fewer per 1000 (CI 95% 117 fewer - 70 fewer)	Moderate Due to serious inconsistency.	Probiotics appear to decrease the incidence of AAD.

Decision support



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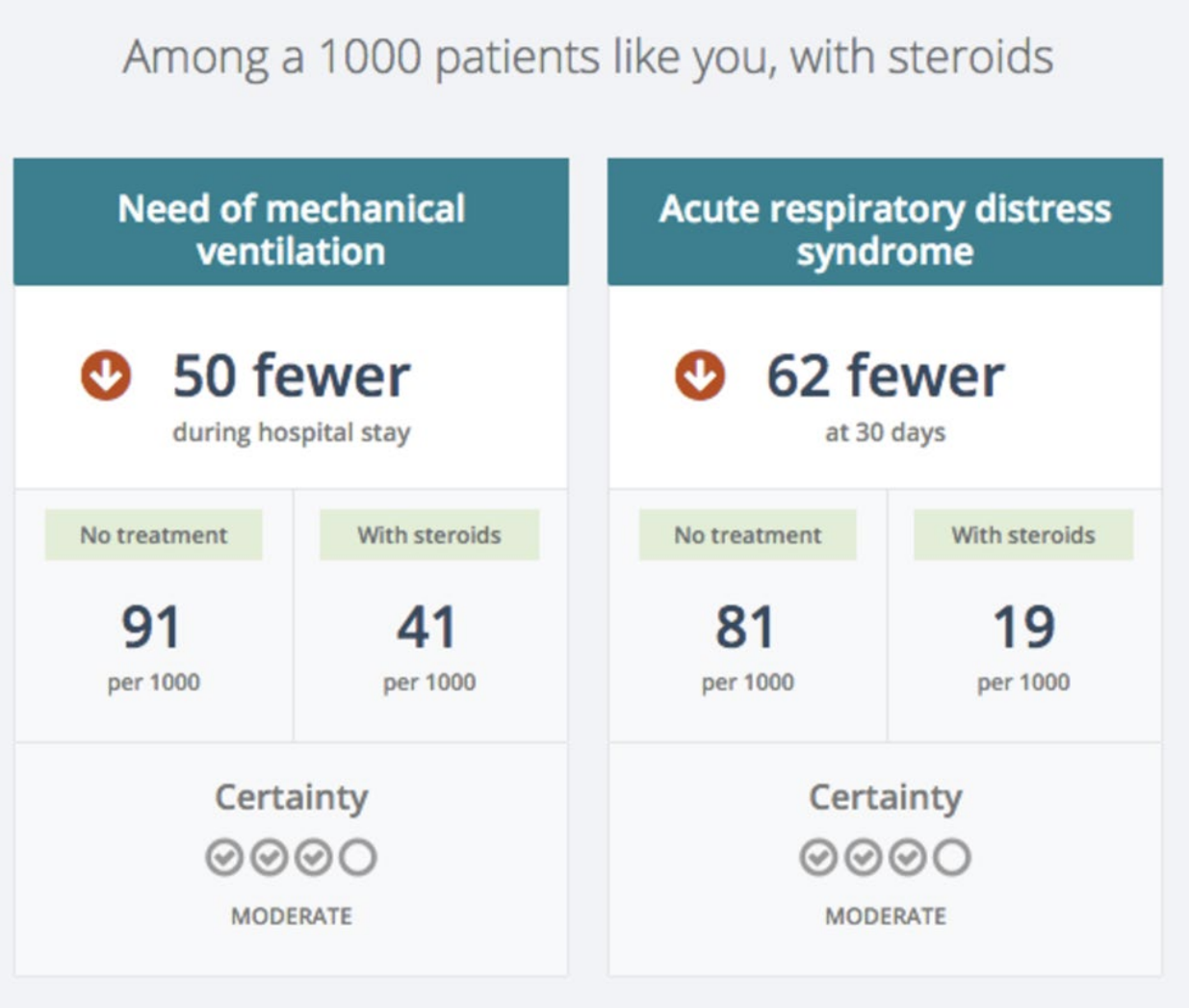
Decision aids



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ABOUT
THE PLATFORM
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CENTER FOR GLOBAL CLINICAL RESEARCH DATA
A global clinical trial
data sharing platform
Purpose-driven data sharing to enhance scientific discovery & public trust

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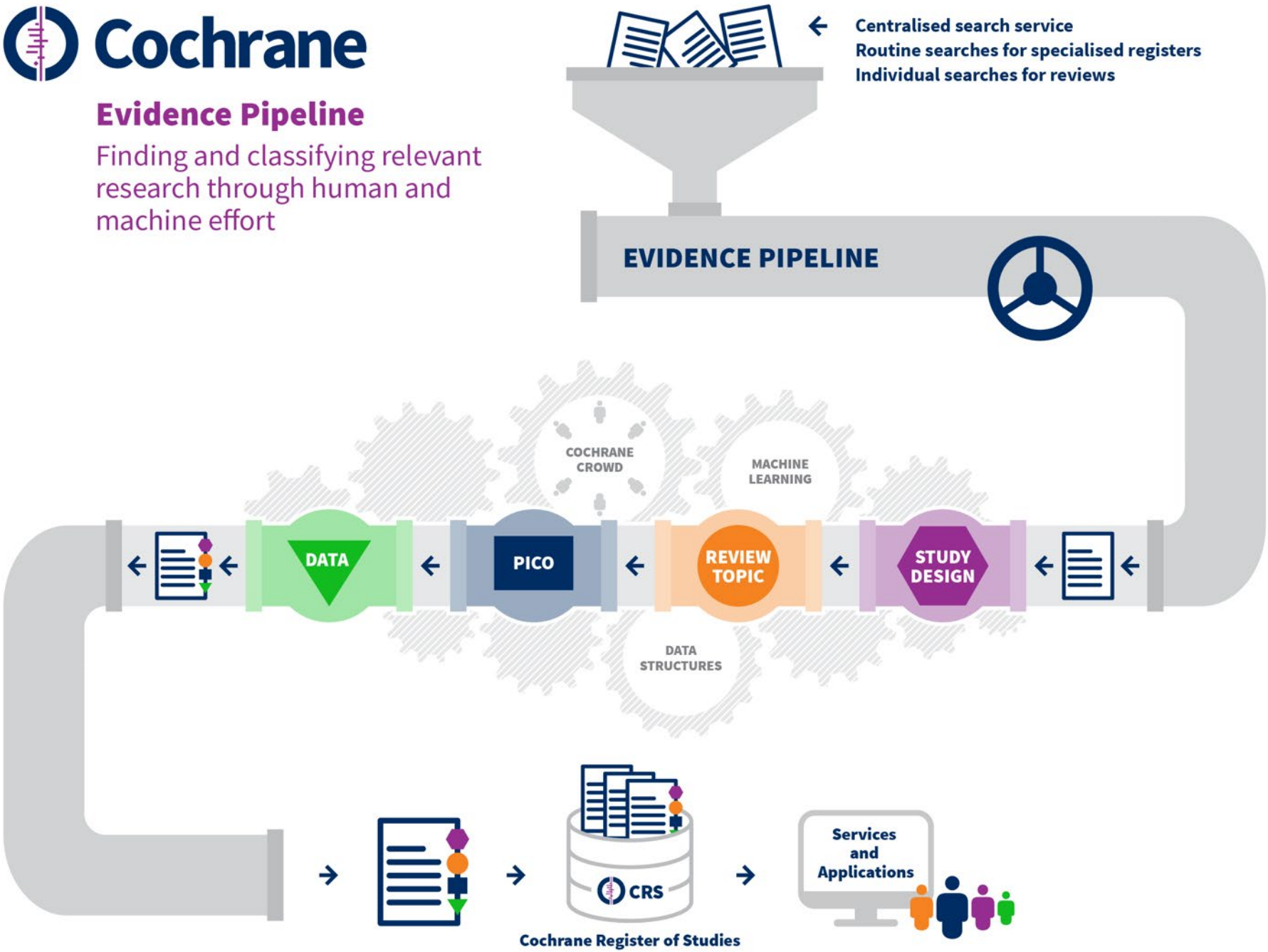
Evidence Pipeline

Finding and classifying relevant research through human and machine effort



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Policy Forum

Living Systematic Reviews: An Emerging Opportunity to Narrow the Evidence-Practice Gap

Julian H. Elliott[1,2*], Tari Turner[2,3], Ornella Clavisi[4], James Thomas[5], Julian P. T. Higgins[6,7], Chris Mavergames[8], Russell L. Gruen[4,9]

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The Bridge from Evidence to Practice

Health research promises societal benefit by making better health possible. However, there has always been a gap between research findings (what is known) and health care practice (what is done), described as the "evidence-practice" or "know-do" gap [1]. The reasons for this gap are complex [2], but it is clear that synthesising the complex, incomplete, and at times conflicting findings of biomedical research into forms that can readily inform health decision making is an essential component of the bridge from "knowing" to "doing."

Systematic reviews (SRs) and meta-analyses have provided incalculable benefit for human health by contributing to the

Summary

- The current difficulties in keeping systematic reviews up to date leads to considerable inaccuracy, hampering the translation of knowledge into action.
- Incremental advances in conventional review updating are unlikely to lead to substantial improvements in review currency. A new approach is needed.
- We propose living systematic review as a contribution to evidence synthesis that combines currency with rigour to enhance the accuracy and utility of health evidence.
- Living systematic reviews are high quality, up-to-date online summaries of health research, updated as new research becomes available, and enabled by improved production efficiency and adherence to the norms of scholarly communication.
- Together with innovations in primary research reporting and the creation and use of evidence in health systems, living systematic review contributes to an emerging evidence ecosystem.

something to offer. Next year the *Oxford Database of Perinatal Trials*[3] will be published by Oxford University Press in electronic form. Besides registers of published[4] and unpublished trials and trials in progress or planned, the data base will include a library of trial overviews which will be updated when new data become available.

Oxford Database of Perinatal Trials,
National Perinatal Epidemiology Unit,
Radcliffe Infirmary,
Oxford OX2 6HE

IAIN CHALMERS

Chalmers I (1986) Electronic publications for updating controlled trial reviews. Lancet 328: 287.

Living Systematic Review

"A systematic review that is continually updated, incorporating new evidence as it becomes available."

Key elements:

- **"Systematic review"**
- **"Continually"**
- **"Updated"**
- **"Incorporating new evidence"**

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Key implications

Category	Item	Description
Production	Work processes	Search strategy maintained and fed continually into workflow
	Team management	Coordinated and ongoing effort
	Methods	Pre-specified approach to search, meta-analysis and updating
Publication	Publication format	Persistent, dynamic, online-only publication

Cochrane Database of Systematic Reviews

Interventions for increasing fruit and vegetable consumption in children aged five years and under

Review | Intervention

Rebecca K Hodder, Fiona G Stacey, Kate M O'Brien, Rebecca J Wyse, Tara Clinton-McHarg, Flora Tzelepis, Erica L James, Kate M Bartlem, Nicole K Nathan, Rachel Sutherland, Emma Robson, Sze Lin Yoong, Luke Wolfenden

First published: 24 January 2018

Editorial Group: Cochrane Heart Group

DOI: 10.1002/14651858.CD008552.pub4 View/save citation

Cited by (CrossRef): 0 articles Check for updates

Living Evidence

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FEATURED ARTICLE

RESEARCH ARTICLE metrics AWAITING PEER REVIEW

Towards a new model for producing evidence-based guidelines: a qualitative study of current approaches and opportunities for innovation among Australian guideline developers [version 1; peer review: awaiting peer review]

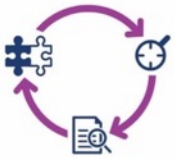
Steve McDonald, Julian H. Elliott, Sally Green, Tari Turner

PEER REVIEWERS Invited

FUNDERS Cochrane | National Health and Medical Research Council

Living Guideline

"A guideline in which individual recommendations are updated as soon as relevant new evidence becomes available."



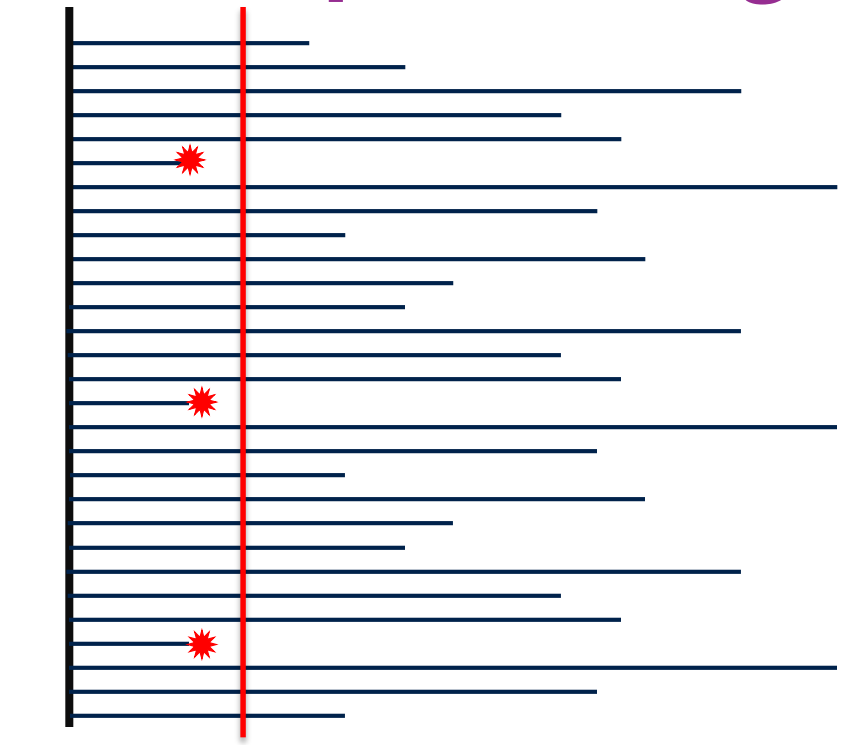
Key elements:

- **"Guideline"**
- **"Individual recommendations"**
- **"Updated"**
- **"Relevant new evidence"**

When to update the guidelines?

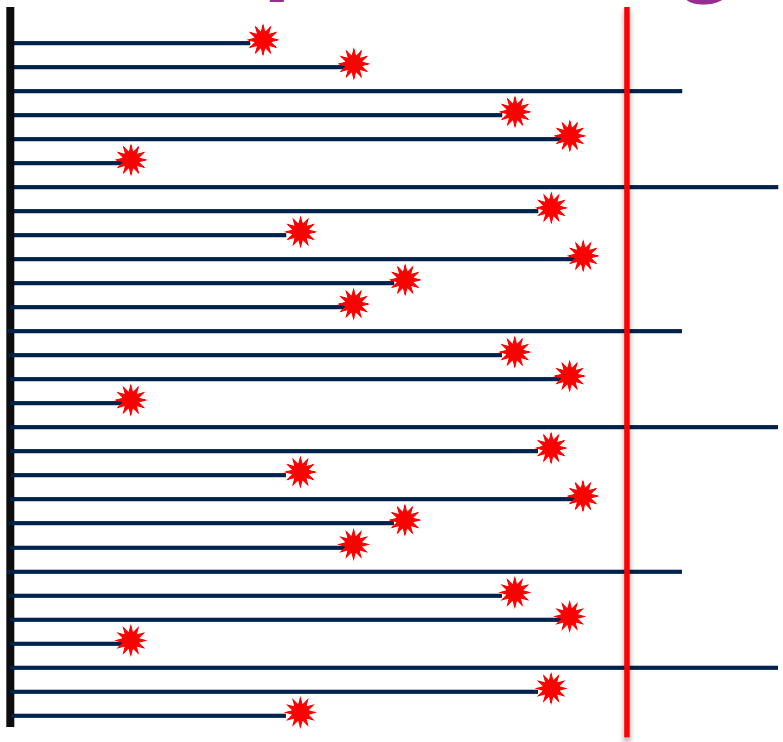
Publication
of the
guidelines

When to update the guidelines?



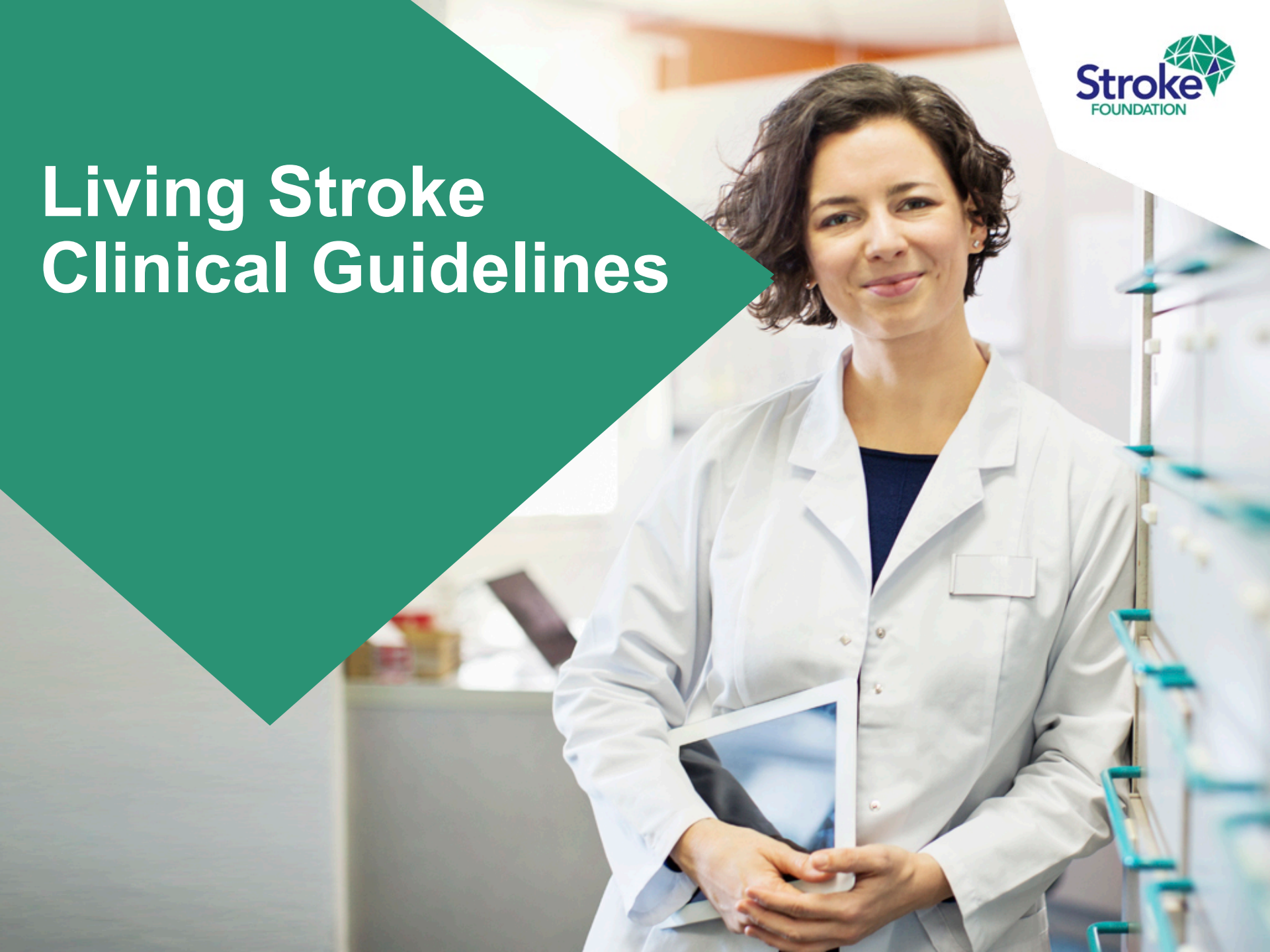
Publication of the guidelines

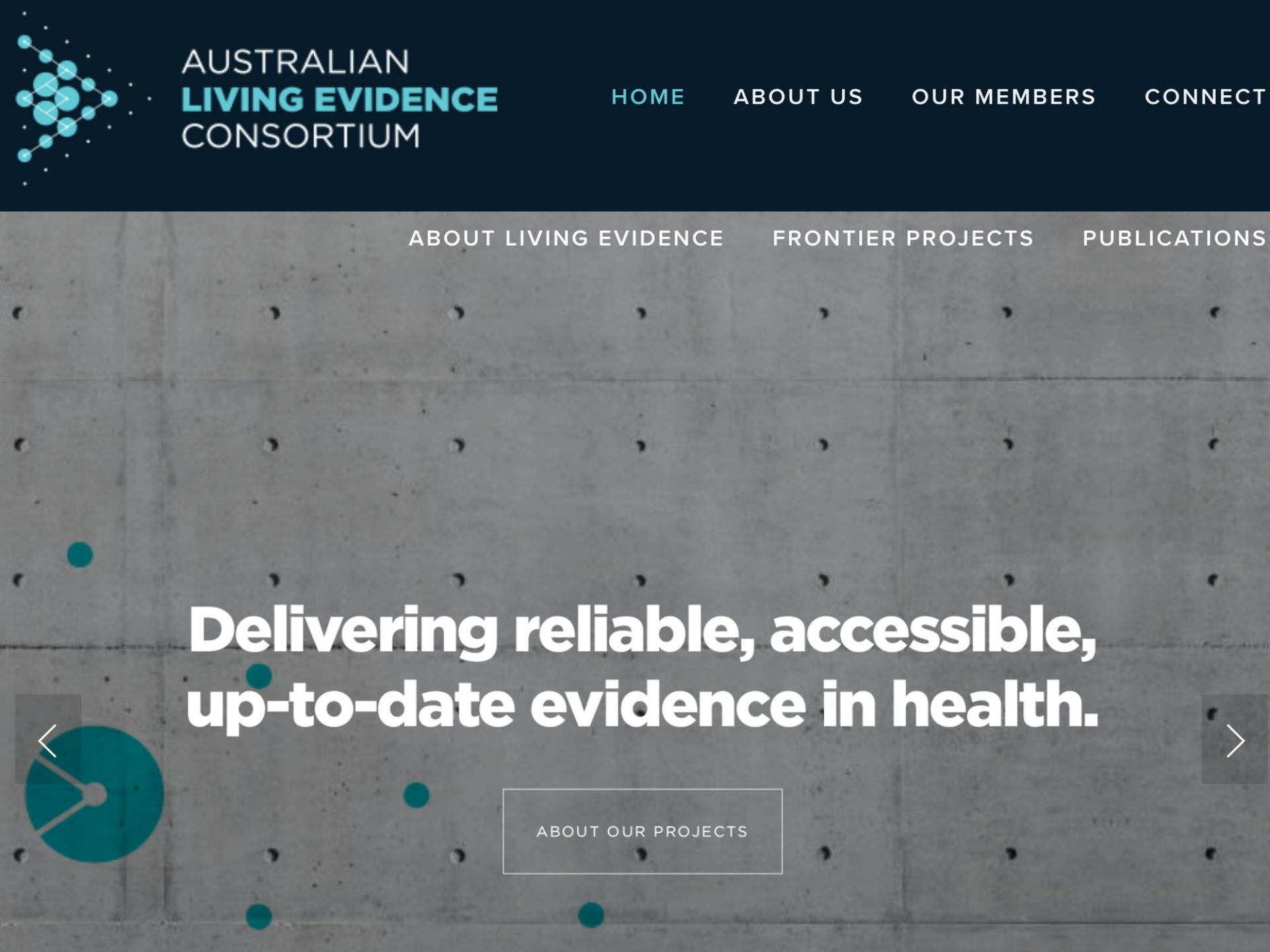
When to update the guidelines?



Publication of the guidelines

Living Stroke Clinical Guidelines




AUSTRALIAN
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FRONTIER PROJECTS
PUBLICATIONS
Delivering reliable, accessible, up-to-date evidence in health.
ABOUT OUR PROJECTS

AUSTRALIAN LIVING EVIDENCE CONSORTIUM

1. Products and Processes

- adopts a continuous workflow for near real-time updating whenever new research warrants a change in practice or policy
- enables living evidence 'products', including living guidelines, living policy briefs and living health technology assessments

2. Platforms and Precision

- harnesses software platforms, machine learning and crowd-sourcing to reduce unit costs of evidence production
- develops methods for using individual-level data to deliver and monitor personalised guidance in learning healthcare systems

3. Partnerships and People

- engages consumers, clinicians, policymakers and international partners in evidence co-production
- builds a critical mass of organisational and professional capability to deliver reliable, accessible, up-to-date evidence

The Living Evidence Network

- 200+ members
- Researchers, guideline developers, professional medical associations, HTA developers
- Cochrane and non-Cochrane
- Considerable expertise and interest within the Network
- Resources, meetings, webinars, pilots
- cochrane.org/lsr

Research must be actively pursued and developed and as fast as new knowledge is acquired it must be applied

Commonwealth Minister for Health

William (Billy) Hughes, 1936

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Living Evidence Network interest group leads

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Task Exchange: Chris Mavergames, Julian Elliott, Tari Turner
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